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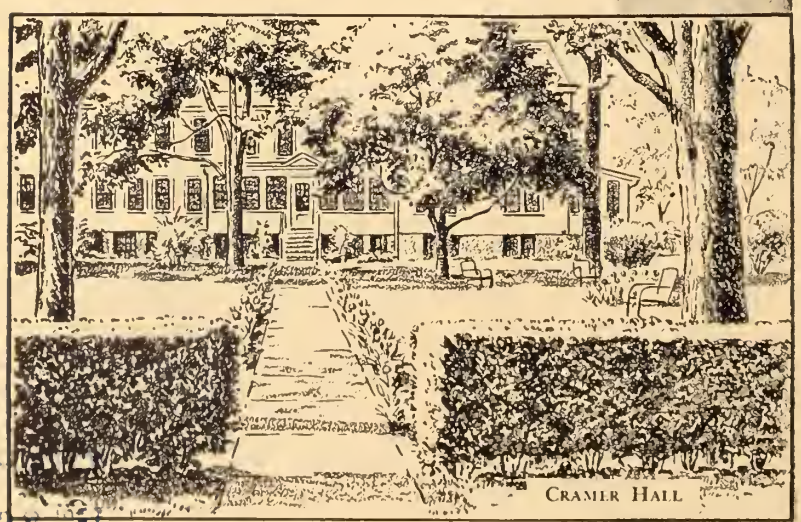
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C. If the insured ceases to be an active member of The Medical Society of New Jersey.
D. If renewal is refused on all policies issued to all members of the Society, in which event 60 days prior notice in writing must be given.

ANNUAL PREMIUM RATES*

(Applicable to ages at entry and attained at annual renewal of insurance)

Monthly Benefits	Dismemberment Benefits	Ages up to 50 Next Birthday	Ages 51 to 60 Next Birthday	Ages 61 to 65** Next Birthday
$100.00	$ 5,000	$ 29.50	$ 34.00	$ 43.00
150.00	7,500	43.60	50.35	63.85
200.00	10,000	57.70	66.70	84.70
300.00	15,000	85.90	99.40	126.40
400.00	20,000	114.10	132.10	168.10
500.00	20,000	141.30	163.80	208.80
600.00	20,000	168.50	195.50	249.50

* Premiums may be paid half-yearly or quarterly, pro-rata.

* All rates above INCLUDE $1000 Accidental Death Benefit. Additional Accidental Death Benefit up to $4000 (making a total of $5000) may be procured for an additional annual premium of $1.30 per $1000.

Coverage for hospitalization and nursing fees is available at a small additional premium.

** Although the age limit for acceptance of risks is the 65th birthday, once issued there is no termination age limit for renewal and the rates of the last age group remain stationary.

This Company has been in business more than fifty-eight years and is one of the leading writers of Accident and Health Insurance, with a surplus to policy holders of more than seven million dollars.

If you are not insured under this plan or if you want further information, communicate with the undersigned managers.

Issued Exclusively by

NATIONAL CASUALTY COMPANY

Through

E. and W. BLANKSTEEN, Mgrs.

Authorized Disability Insurance Representatives of The Medical Society of New Jersey

75 MONTGOMERY STREET DElaware 3-4340 **JERSEY CITY 2, N. J.**

SPECIAL ANNOUNCEMENT

To the Members of The Medical Society of New Jersey

We are happy to announce the approval of

THE EXTENDED PROFESSIONAL DISABILITY POLICY

under the Group Disability Plan with the NATIONAL CASUALTY COMPANY sponsored by your Society.

For a modest additional premium you can add this policy to your present one in this group and assure yourself of an income in case of an extended disability beyond the limits of coverage provided in the basic Physicians' Special Policy which you now carry with the National Casualty Company as a member of this Society.

Your basic policy provides monthly benefit for two years in the event of a sickness disability, and five years for an accident disability.

FEATURES OF THE NEW POLICY—

1. ACCIDENT BENEFITS—Continued for life.
2. SICKNESS BENEFITS—continued for five additional years, making a total of seven years.

ELIGIBILITY—

1. You must hold a basic policy in the group.
2. You must be under age 60.
3. Acceptable physical risks may purchase up to $400 a month but for no greater amount than that carried in the basic plan.
4. Impaired risks are eligible for not more $200 per month if 75% of the existing policyholders, under age 60, apply during sixty (60) day charter enrollment to be announced by mail to policyholders under age 60.

The enrollment period will not be extended. We heartily recommend this policy to you for your immediate consideration.

Those not presently insured under the basic policy described on the opposite page may apply to the agency for a basic policy as well as for the extended coverage and policies will be issued if they are acceptable risks, in accordance with the company's underwriting rules and regulations.

ANNUAL PREMIUM RATES*

(APPLICABLE TO AGES AT ENTRY AND ATTAINED AT ANNUAL RENEWAL OF INSURANCE)

Monthly Benefits	Ages up to 50 Next Birthday	Ages 51 to 60 Next Birthday	Ages 61 to 65** Next Birthday
$100.00	$ 11.00	$ 14.00	$ 18.00**
200.00	22.00	28.00	36.00**
300.00	33.00	42.00	54.00**
400.00	44.00	56.00	72.00**

*Premiums may be paid half-yearly or quarterly pro-rata, concurrently with basic policy
**Renewal premiums only. This extended policy not renewable beyond 65th birthday.

24-hour control

for the majority of diabetics



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a clear solution . . . easy to measure accurately

Discovered by Reiner, Searle, and Lang
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BRAND OF TETRACYCLINE

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Tetracycline is notable among broad-spectrum antibiotics for its solubility and stability. And, clinical trials have established that tetracycline is an efficient antibiotic against those diseases due to susceptible microorganisms.

Tetracyn is available in a variety of oral, parenteral and topical dosage forms for the treatment of a wide range of susceptible infections.

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Division, Chas. Pfizer & Co., Inc.
Brooklyn 6, N. Y.



THORAZINE* *can allay the suffering caused by the pain of SEVERE BURSITIS*

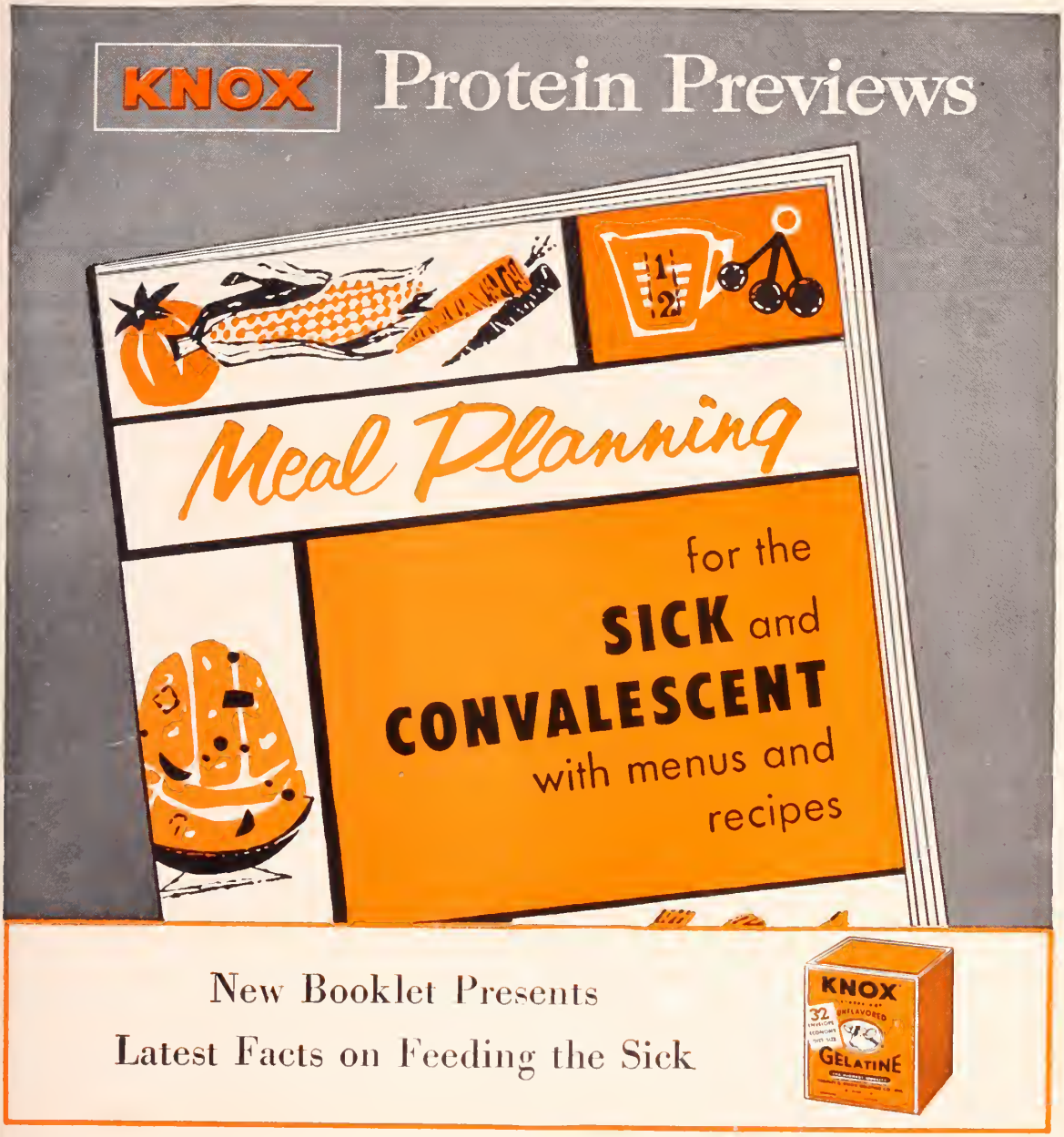
The ataractic, tranquilizing action of 'Thorazine' can reduce the anguish and suffering associated with bursitis. 'Thorazine' acts not by eliminating the pain, but by altering the patient's reaction—enabling her to view her pain with a "serene detachment" . . . Howell and his associates[1] reported: "Several of [our patients] expressed the feeling that ['Thorazine'] put a curtain between them and their pain, so that whilst they were aware that the pain existed, they were not upset by it."

'Thorazine' should be administered discriminately and with the care to be observed with all serious medication. Consequently, it is important that the physician, before prescribing 'Thorazine', be fully conversant with the available literature.

Smith, Kline & French Laboratories, Philadelphia

1. Howell, T.H.; Harth, J.A.P. and Dietrich, M.: Practitioner *173*:172.
*T.M. Reg. U.S. Pat. Off. for chlorpromazine, S.K.F.

KNOX Protein Previews



New Booklet Presents Latest Facts on Feeding the Sick

Adequate nutrition during illness and convalescence is essential for recovery whether the patient is managed in the hospital or at home. In the latter case, physicians often must devote much time to instructing those responsible for caring for the sick in good nutritional practices.

"Meal Planning for the Sick and Convalescent" has been designed to relieve you of the need for repeating over and over again essential dietary facts. This new Knox booklet presents in layman's language the latest nutritional applications of proteins, vitamins and minerals, gives practical hints on serving food to adults and children, suggests ways to stimulate appetite and describes diets from clear liquid to full convalescent. Best of all it offers the homemaker for the first time detailed daily suggested menus for each type of diet, plus 14 pages of tested nourishing recipes.

If you would like copies of this new timesaving Knox booklet for your practice, use the coupon below.

Chas. B. Knox Gelatine Company, Inc.
Professional Service Department SJ-13
Johnstown, N. Y.

Please send me.....copies of the new Knox "Sick and Convalescent" booklet.

YOUR NAME AND ADDRESS

the drug of choice

. . . as a tranquilizing (ataractic) agent*
in anxiety and tension states
. . . in hypertension

RAUDIXIN

Squibb Whole Root Rauwolfia

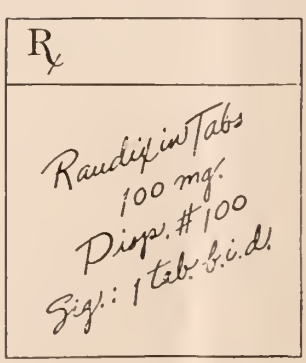
As a tranquilizing agent in office practice, Raudixin produces a calming effect, usually free of lethargy and hangover and without the loss of alertness often associated with barbiturate sedation. It does not significantly lower the blood pressure of normotensive patients.

In hypertension, Raudixin produces a gradual, sustained lowering of blood pressure. In addition, its mild bradycardic effect helps reduce the work load of the heart.

- Less likely to produce depression
- Less likely to produce Parkinson-like symptoms
- Causes no liver dysfunction
- No serial blood counts necessary during maintenance therapy

- Raudixin is not habit-forming; the hazard of overdosage is virtually absent. Tolerance and cumulation have not been reported.
- Raudixin supplies the *total* activity of the whole rauwolfia root, accurately standardized by a rigorous series of test methods. The total activity of Raudixin is not accounted for by its reserpine content alone.

Supply: 50 mg. and 100 mg. tablets, bottles of 100 and 1000.



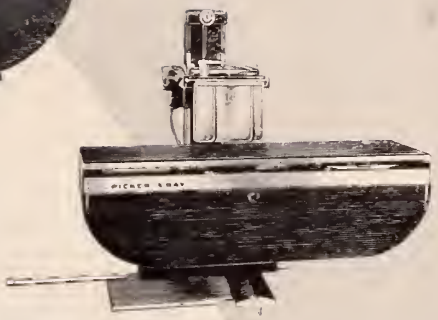
*Ataractic, from ataraxia: calmness untroubled by mental or emotional excitation. (Use of term suggested by Dr. Howard Fabing at a recent meeting of the American Psychiatric Association.)

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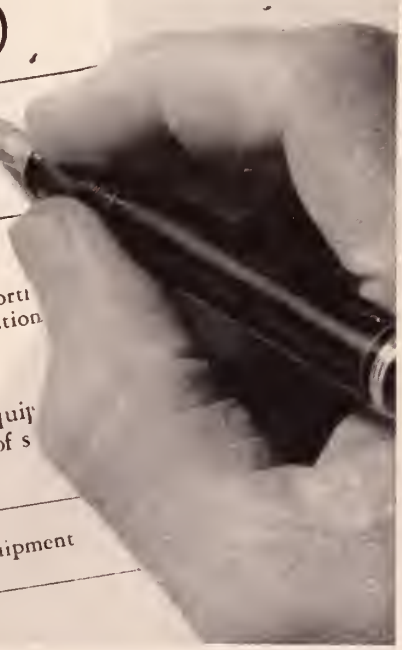
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Subject to your acceptance of the terms and conditions set forth
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address, its Rental Service, comprising:

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2. The replacement of tubes which are part of such equip
3. Technical service and instruction in the operation of s
4. Maintenance of the equipment.

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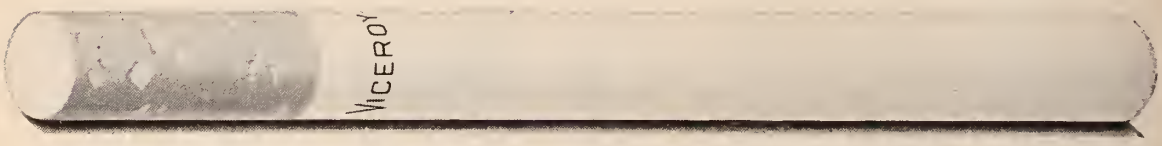
-) rapid diffusion and penetration
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-) negligible side effects
-) true broad-spectrum activity (proved effective against a wide variety of infections caused by Gram-positive and Gram-negative bacteria, rickettsiae, and certain viruses and protozoa)
-) every gram produced in Lederle's *own* laboratories under rigid quality control, and offered *only* under the Lederle label
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EDERLE LABORATORIES DIVISION *AMERICAN Cyanamid COMPANY* PEARL RIVER, NEW YORK

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The VICEROY filter tip contains 20,000 tiny filters made exclusively from pure, white cellulose. This is twice as many as the next two largest-selling filter brands.

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when sniffles hit the classroom

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NASAL CONGESTION
MAKES YOUNGSTERS
MISERABLE



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contains Zephiran® chloride 1:5000, antibacterial wetting agent and preservative far greater efficiency

*Designed specifically for children**

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New Concepts of Optimal Nutrition
during THE SECOND FORTY YEARS



Optimal nutrition at all ages is promoted *excellently* by *routine* use of VITA-FOOD Brewers' Yeast: "Brewers' yeast is an excellent source of proteins of high biologic value and of the vitamins of the B complex."[1]

Eminently valuable too are its unsurpassed digestibility, its content of minerals and lipotropic factors, its virtually ideal nutritional *balance*—for normal CO-ACTION of essential nutrients, a synergism indispensable to enduring vigor.[1, 3]

Brewers' yeast is authoritatively attested to be "one of the most useful foods for older people . . . economical . . ."[2] and "frequently helpful in rehabilitating older patients"[3]—in whom the extreme SUBTLETY of cumulative nutritional insults is fostered by TIME, which may also bring increased demands for proteins and vitamins. [1, 3]

For prevention and in dietotherapy of many disorders throughout THE SECOND FORTY YEARS, *prescribe as a routine supplement*

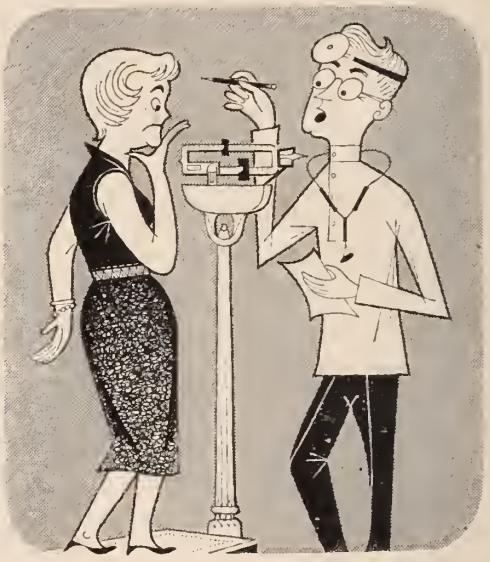
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Brewers' Yeast

the richest *natural* source of vitamin B complex factors plus nutritionally complete protein, essential minerals and lipotropic factors.

Send for Samples to Department NJ
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1. McLester and Darby: "Nutrition and Diet in Health and Disease," ed. 6, Saunders, p. 195. 2. McCay, C. M., in Lansing: "Problems of Aging," ed. 3, Williams and Wilkins, 1952, p. 193. 3. Sebrell and Hundley, in Stieglitz: "Geriatric Medicine," ed 3, Lippincott, 1954, p. 189.

Doctor! don't say "no"
say NO-CAL



the delicious sparkling soft drink that's absolutely non-fattening

- All the natural flavor and zest of regular soft drinks!
- Contains absolutely no sugar or sugar derivatives! No fats, carbohydrates or proteins and no calories derived therefrom!
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With so many antibacterial drugs to choose from, you may wonder which one to prescribe. We believe you'll agree that most of them are rather good. Still, we hope you'll try Gantrisin® 'Roche'...because this single sulfonamide is soluble in both acid and alkaline urine... because it has a wide antibacterial spectrum... an impressive clinical background...and, above all, because it's so well tolerated by most patients.

for antibacterial therapy without "medicine taste"

the pure raspberry flavor of this convenient Gantrisin (acetyl) Pediatric Suspension 'Roche' is so appealing that youngsters accept each dose without balking. The acetyl form provides the same wide-spectrum effectiveness, high plasma and urine levels and virtual freedom from gastrointestinal upsets as other oral dosage forms of Gantrisin, a widely used single sulfonamide.

Gantrisin® acetyl -- brand of acetyl sulfisoxazole

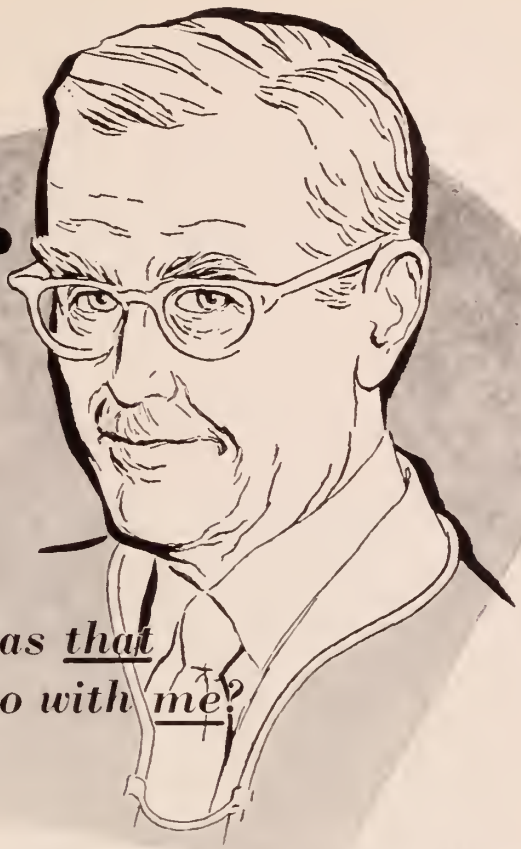
Gantrisin® -- brand of sulfisoxazole

Hoffmann - La Roche Inc · Nutley · N.J.

Bovie?..

sure, our hospital uses Bovies –

- but what has <u>that</u> to do with <u>me</u>?



That's a question we like to answer. Doctor! No one knows better than you that America's family doctors are finding more and more people dependent on them for a greater-than-ever degree of personally-administered medical care. That's where the OFFICE BOVIE comes into the picture . . . because it provides dependable office electrosurgery to *extend* and *augment* your medical practice.

The "little" Bovie is proving a *big* help to doctors interested in doing *more* for their patients. Have *you* considered the OFFICE BOVIE for use in your office? Thousands of doctors *are* using it daily for a host of useful minor surgical techniques. *We'd like to send you, without obligation, an interesting 6-page illustrated brochure on this important subject . . .*

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ELECTROSURGICAL UNIT
—made by Liebel-Flarsheim, makers of the famous Hospital type Bovie Electrosurgical Units.

THE LIEBEL-FLARSHEIM CO.
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Gentlemen: Please send me, without obligation, your latest descriptive brochure on the OFFICE BOVIE Electrosurgical Unit.

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Pork in the Human Dietary

PORK MAY be looked upon as an important factor in America's general health and well-being. The average intake of pork in America is about 46 pounds of lean pork and 20 pounds of bacon and salt pork per person each year.[1] But America's demand for pork goes further than taste appeal and deeper than mere statistics. Pork makes a valuable contribution to day-in-and-day-out nutrition.

Pork rates among the foremost sources of thiamine. As a source of all other B vitamins and many essential minerals, such as iron and phosphorus, pork meat is considered an important dietary constituent.

Lean pork is virtually completely digestible. Its protein serves to promote growth and aid in the maintenance of tissue cells. Like all high quality protein, that of pork aids in the elaboration of protein hormones, enzymes, and antibodies.

Pork constitutes a valuable part of the daily diet (Table I), and also contributes importantly to the nutrition of the pregnant woman (Table II).

Pork and pork products have won America's favor by their unique combination of economy, palatability, and nutritional value.

---

1. Consumption of Food in the United States, 1909-1952, Washington, D.C., United States Department of Agriculture, Bureau of Agricultural Economics, Agricultural Handbook No. 62, September, 1953.
2. Watt, B.K., and Merrill, A.L.: Composition of Foods—Raw, Processed, Prepared, Washington, D.C., United States Department of Agriculture, Agricultural Handbook No. 8, 1950.
3. Bowes, A. deP., and Church, C.F.: Food Values of Portions Commonly Used, ed. 7, Philadelphia, Anna dePlanter Bowes, 1951.
4. Cheldelin, V.H., and Williams, R.J.: Studies on the Vitamin Content of Tissues, 11, Houston, Texas, University of Texas Publication No. 4237, 1942.
5. Schweigert, B.S.; Nielsen, E.; McIntire, J.N., and Elvehjem, C.A.: Biotin Content of Meat and Meat Products, J. Nutrition 26:65 (July) 1943.
6. Scheid, H.E., and Schweigert, B.S.: The Vitamin B_{12} Content of Meat, Annual Report, An Outline of Research During the Fiscal Year 1953-54, Chicago, American Meat Institute Foundation, Bull. 22, 1955.
7. Estimated on basis of protein content of meats. Sherman H.C.: Food Products, ed. 4, New York, The Macmillan Company, 1948 p. 155.
8. Recommended Dietary Allowances, Washington, D.C., National Academy of Sciences—National Research Council, Publication 302, 1953.

TABLE I — Cooked Pork Chops, Ham, and Pork Sausage
Nutrients and Calories Provided by 3-Ounce Portions

	Protein Gm.	Thiamine mg.	Niacin mg.	Riboflavin mg.	Iron mg.	Phosphorus mg.	Calories
Pork Chops, without bone, cooked, 3 oz.[2]	20	0.71	4.3	0.20	2.6	200	284
Ham, without bone, cooked, 3 oz.[2]	20	0.45	4.0	0.20	2.6	202	338
Pork Sausage, cooked, 3 oz.[3]	14	0.42	2.8	0.20	2.1	139	396

3.5 ounces of fresh pork loin, equivalent to approximately 3 ounces of cooked loin, contains 0.47 mg. pantothenic acid;[4] 0.10 mg. pyridoxine;[4] 0.005 mg. biotin;[5] 36 mg. inositol;[4] 0.08 mg. folic acid;[4] 0.0027 mg. vitamin B_{12};[6] 63 mg. chlorine;[7] 0.1 mg. copper;[7] 20 mg magnesium;[7] 280 mg. potassium;[7] 70 mg. sodium;[7] and 0.01 mg. manganese.[7]

TABLE II — Nutrients and Calories of Cooked Pork Chops (3 ounces) Expressed as Percentages of Recommended Daily Dietary Allowances[8]

Percentages of Allowances for:	Protein	Thiamine	Niacin	Riboflavin	Iron	Phosphorus	Calories
Girls, 13-15 years of age; weight, 108 lb.; height, 63 inches.	25%	55%	33%	10%	17%	15%	11%
Women, 25 years of age; weight, 121 lb.; height, 62 inches.	31%	59%	36%	14%	22%	17%	12%
Pregnant Women (3rd trimester)	25%	47%	29%	10%	17%	13%	11%

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

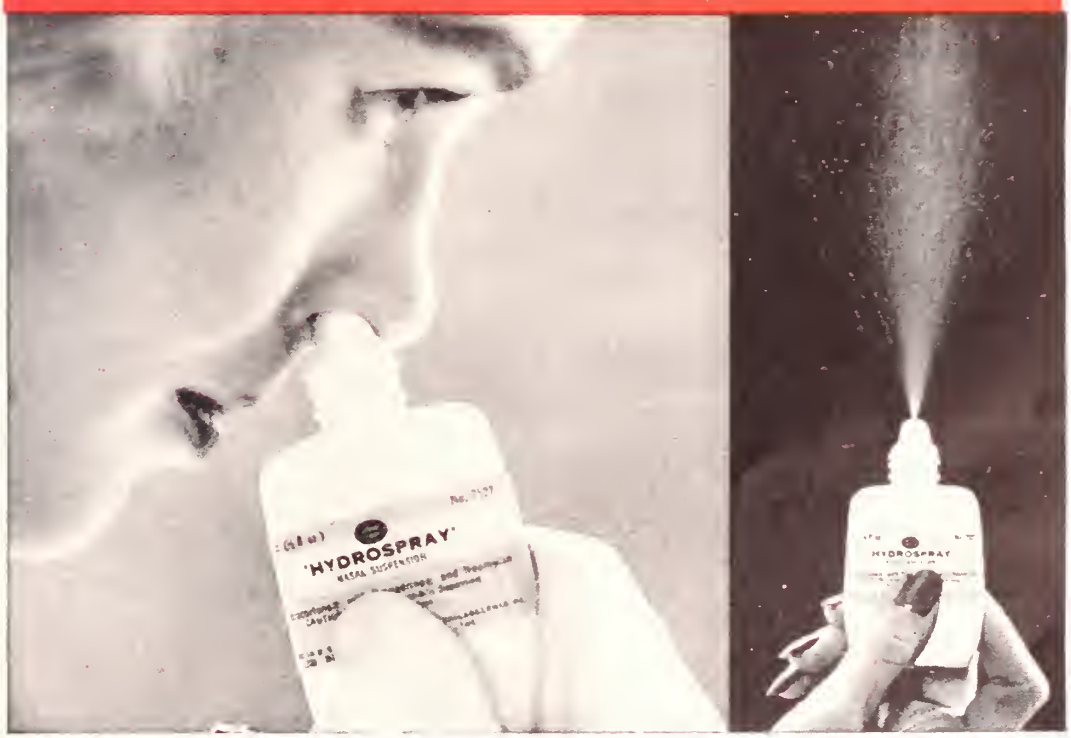
American Meat Institute
Main Office, Chicago... Members Throughout the United States

'Hydrospray' NASAL SUSPENSION

(HYDROCORTONE® WITH PROPADRINE® AND NEOMYCIN)

Anti-inflammatory—
Decongestant—Antibacterial

MAJOR ADVANTAGES: New synergistic anti-inflammatory, decongestant and antibacterial formula. High steroid content assures effective response.



Topically applied hydrocortisone[1] in therapeutic concentrations has been shown to afford a significant degree of subjective and objective improvement in a high percentage of patients suffering from various types of rhinitis. HYDROSPRAY provides HYDROCORTONE in a concentration of 0.1% plus a safe but potent decongestant, PROPADRINE, and a wide-spectrum antibiotic, Neomycin, with low sensitization potential. This combination provides a three-fold attack on the physiologic and pathologic manifestations of nasal allergies which results in a degree of relief that is often greater and achieved faster than when any one of these agents is employed alone.

INDICATIONS: Acute and chronic rhinitis, vasomotor rhinitis, perennial rhinitis and polyposis.

SUPPLIED: In squeezable plastic spray bottles containing 15 cc. HYDROSPRAY, each cc. supplying 1 mg. of HYDROCORTONE, 15 mg. of PROPADRINE Hydrochloride and 5 mg. of Neomycin Sulfate (equivalent to 8.5 mg. of neomycin base).

SHARP & DOHME

Philadelphia 1, Pa.
DIVISION OF MERCK & CO., INC.

REFERENCE: 1. Silcox, L. E., *A.M.A. Arch. Otolaryng.* 60 431, Oct. 1954



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BABY SERVICE HAS CREATED AN OUTSTANDING HOSPITAL SERVICE DIVISION

Offering:

Now serving many of New Jersey's Leading Hospitals.

- **Daily pick-up and delivery.**
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Also Individual Diaper Service for the Home

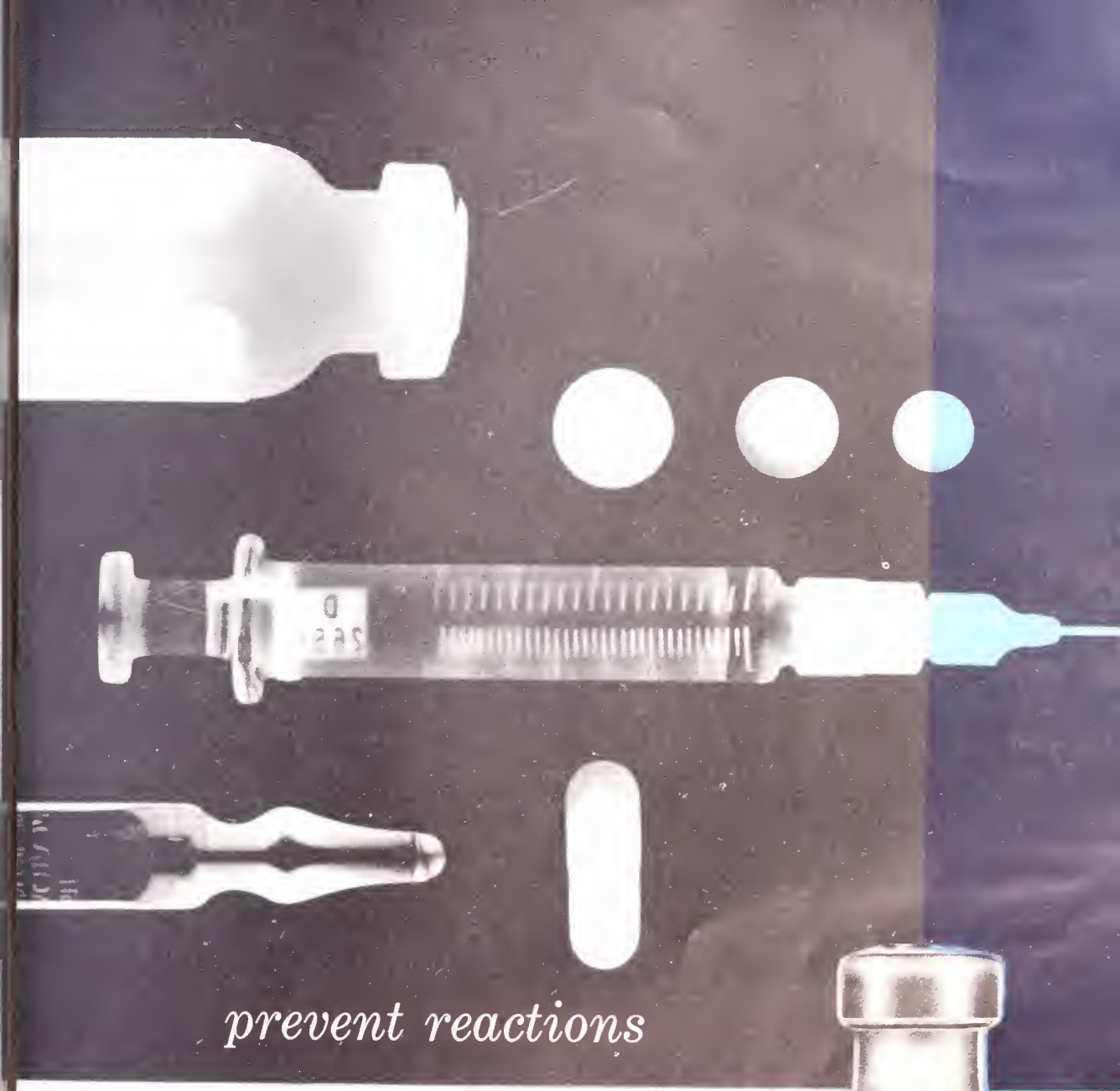
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- All plant operations are carefully supervised. A chemical check is continuously made, and bacteria colony counts of the diapers are run.
- A modern tested diaper supply service for our customer's exclusive use.



Safe! Individual! Dependable!



prevent reactions



To safeguard your patients add 1 cc. of CHLOR-TRIMETON Injection 100 mg./cc. to each 10 cc. vial of aqueous penicillin.

Supplied: 2 cc. multiple-dose vial. For intramuscular and subcutaneous administration.

CHLOR-TRIMETON ® maleate, brand of chlorprophenpyridamine maleate.



Effective New Therapy

For Constipation

Revealed in Hospital Research Report

DANNON Prune Whip YOGURT successful in 95% of chronic cases when taken every night for 3 weeks

An important study of chronic constipation at a New York hospital discloses these striking results:*

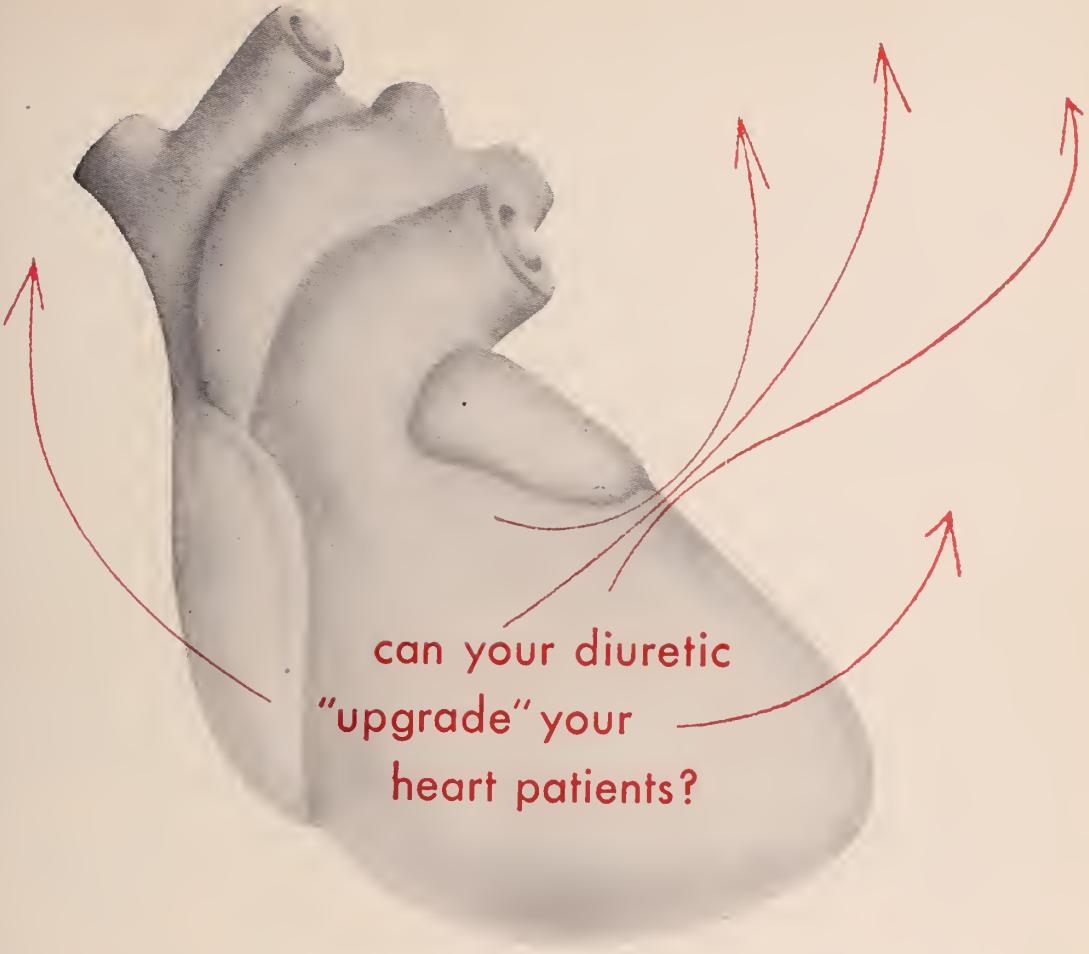
> In a group of 194 chronically ill patients, averaging 71.6 years of age, regular feeding of Dannon Prune Whip Yogurt produced excellent results. Completely normal bowel habits were re-established in 187 patients, or 95.8%. They required no laxatives during the period of administration. Improvement in skin tone, seborrheic dermatitis, intestinal stasis and pruritus ani were also noted.

Here is a natural, physiological approach which offers an effective solution to the widespread problem of faulty evacuation.

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*Ferrer, F. P., and Boyd, L. J.: Am. J. Dig. Dis., 22:272, 1955



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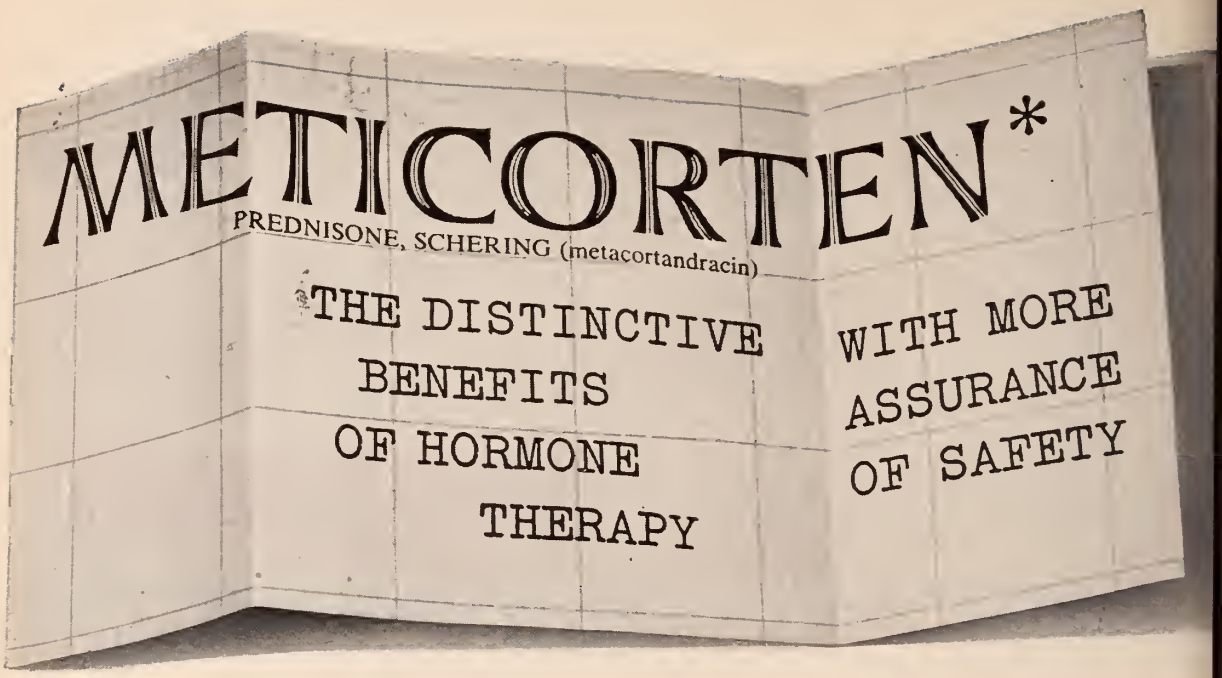
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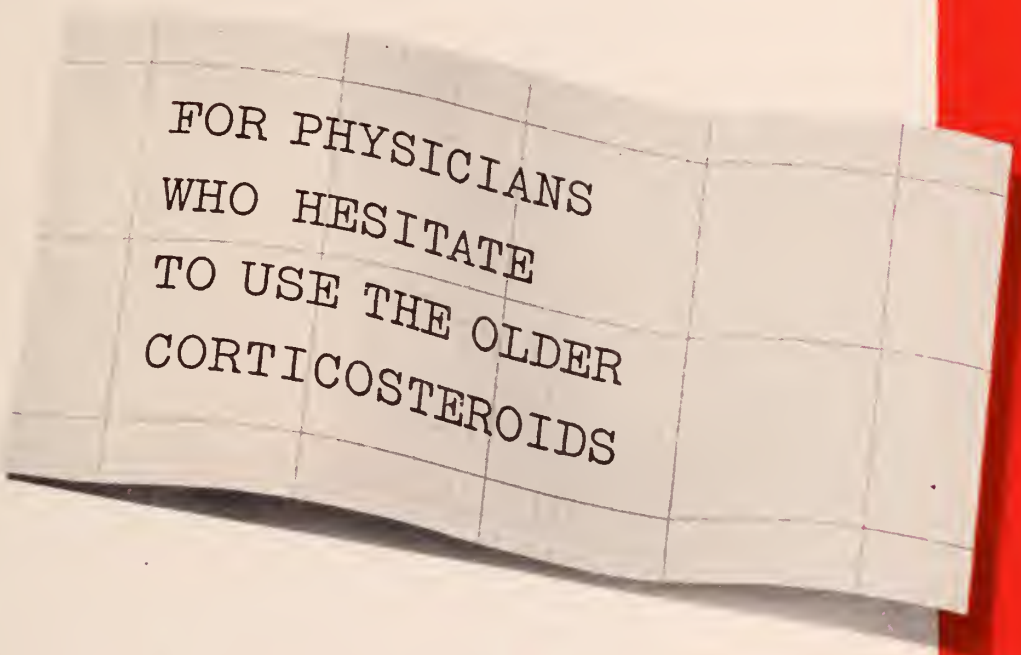
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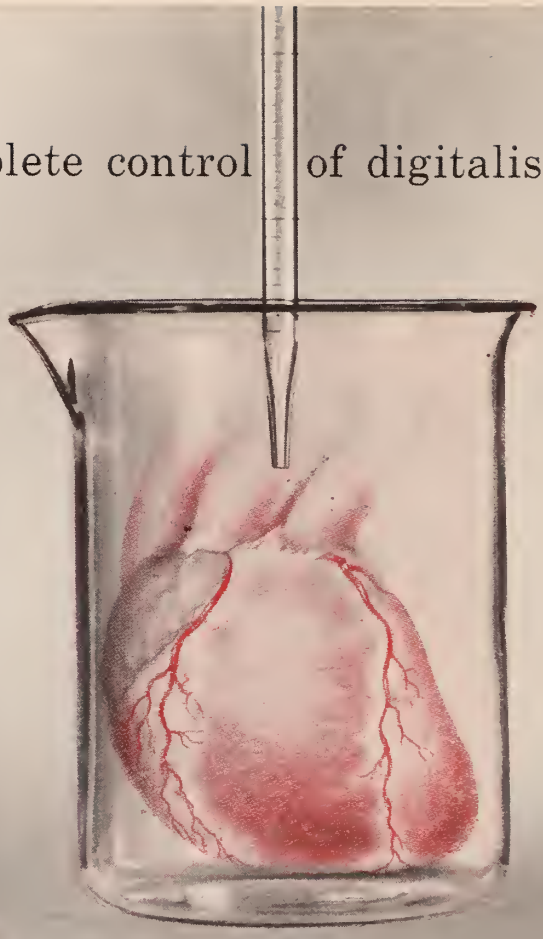
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Editorials • • •

Therapeutic Gullibility

Those of us who have been out of medical school more than 25 years will remember that we were educated during a period of therapeutic nihilism. While we talked about alteratives, febrifuges and stomachics, we did not—most of us—really expect iodides to soften up the sclerosed arteries, nor did we really think that nux vomica was a potent stimulant. In private councils we were willing to concede that I.Q. and S. exercised only a placebo-effect, even though it contained allegedly anti-anemic and stimulant ingredients. There was an all-pervading aura of skepticism about drugs.

The pendulum began to swing in 1925 when we learned how to crystallize insulin and discovered that it really worked. Two years later came ephedrin, and in 1935 Domagk proved the therapeutic value of Prontosil* and thus opened the door to chemotherapy. In 1938 came Dilantin®. In 1940 the vast usefulness of penicillin was established and the first page of the new book of antibiotics was turned. In 1943 ACTH was developed and in the following year came streptomycin, number 1 in the parade of the mycins. The second quarter of this 20th century was an era of wonder drugs. No one knows how many lives have been saved by drugs that no emperor could have commanded when the century was young.

And so therapeutic nihilism came to be replaced by therapeutic optimism. We now call for vitamins, anti-histaminics, tranquillizers, antibiotics, relaxants and antispasmodics, in huge quantities. We place sedatives and stimulants within the same capsule with the hope that they will reinforce instead of neutralize each other. The dazzling patter of the huckster has invaded our medical temples. While we laugh at the extravagance of cigarette or movie advertising, we often swallow without straining the comparable fantasies of the multi-colored brochure that falls on the desk. It's soothing but potent says one notice. It calms but does not depress says another. No side-effects promises a third. Pre-

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vents bleeding by counteracting vascular fragility reads one implausible advertisement. Works synergistically to provide relief from both irritability and torpor. Contains vasoconstrictor, analgesic, and hygroscopic properties. Highly effective with a wide safety margin. Combines stimulant, relaxant, antacid and vitamin supplement effects. And so on. And on.

Why do we believe all this puffery? If we do *not* believe it, then are we writing prescriptions for psychic effect only? And if we *do* believe it, what has happened to our critical acumen? The answer is this. The pharmaceutical manufacturer can cite experiments, filled with charts, graphs and calculations of chi square, which show the effectiveness of his product. Reputable universities and hospitals report that Shnookie Extract has indeed lowered the blood pressure, decreased nocturnal urgency, and stopped the cough. Who are you to challenge a research project so well financed and so glitteringly supported by statistics? Yet much of the research is poorly designed and badly controlled.

The basic difficulty is not bad faith but bad research critique. Drug research seldom makes adequate allowance for the emotional effect of being in an experiment, and investigators fall into the *post hoc ergo propter hoc* trap. If it is shown that the drug lowers blood pressure, what is done about discounting the emotional effects of being fussed over? The only honest technic is the double-blind method — where a placebo of identical shape, size and color is given to alternate or matched patients, so that none of the doctors or nurses knows which patient gets the placebo, which gets the potent drug. Only then can the emotional factor be ruled out. And when this rigid technic is followed many claims fall. Unfortunately only a minority of drug research projects use this method.

The Therapeutic Trial Committee of the British Medical Research Council showed as long ago as 1950 that placebos did as well as anti-histaminics for the treatment of the common cold. Placebos even provoked the same side-effects. But this rigid experiment is overwhelmed by hundreds of non-controlled studies which suggest that anti-histaminics do help people with colds. So there has been no reluctance to prescribe anti-histaminics—again an example of medical gullibility. Similar experiments done more recently at the University of Minnesota led Howard Diehl to comment dryly that reported results could actually serve as testimonials to the value of the placebo. The Syracuse University group, using penicillin, found it just as effective as (but not better than) aspirin in relieving the cold. But anti-histaminics, antibiotics and chemotherapy are still widely prescribed for common colds.

It takes courage to reject a patter skillfully applied by a brochure or by a detail man. The average doctor feels at a disadvantage because he does not have the technical knowledge of research needed to find flaws in the reported project. And, of course, you never know. The first ten "new" drugs to be touted may be nothing but fantastically expensive variants of an old reliable. Or they may be therapeutically inert. But the eleventh one might be an insulin, a penicillin or a streptomycin. You do not want to be asleep at the switch of history and refuse to prescribe some new alembic which might save a life. So, to be on the safe side, you reach for the prescription pad and call for that new capsule that contains vitamins, stimulants, sedatives, antacids, analgesics, and antipruritics.

No criticism is here intended of the scientists in America's pharmaceutical industry. Humanity owes that industry an unredeemable debt. Our free-enterprise pharmaceutical industry has led to the development of a hundred life-saving, comfort-giving medications. Their scientists work in quiet anonymity to keep burning the Aladdin's lamp of pharmacology. But let it be also recognized that the promoter sometimes pushes aside the pharmaceutical scientist. He, not the scientist, may be getting a free ride on the swinging pendulum.

Has the pendulum gone too far? Has a now discredited therapeutic nihilism been smothered under a naive therapeutic gullibility? A little skepticism may clear a lot of air—much of it hot.

*For the benefit of you young readers, Prontosil was a primitive sulfonamide.

ROBERT B. MARIN, M.D.
Montclair

Business, Money and Medicine

The advantages of periodic health checks for executives are obvious. However, if the company that pays the bill insists on a report, the executive is on the horns of a dilemma. One solution to this dilemma is here proposed by Dr. Marin.

SMALL thinking in health is costing U. S. business millions of dollars a year. Conservatively figured, the annual bill is around nine million dollars, a loss which may well portend a boom in the field of occupational health maintenance. So serious are the man-days lost every year because of temporary disabilities due to non-industrial, industrial sicknesses and accidents that top business management, government and private agencies are urging periodic health check-ups for employees. A healthy employee is a better worker and will produce a better on-the-job record. While health is neither the major responsibility nor under the control of business management, services which contribute toward its improvement are both prudent and profitable. Financial loss to an operating business bears investigation and solution. This attitude has particular pertinence toward the firm's most costly and valuable investment, the employee.

A main obstacle to health maintenance plans for individual businesses has been the obvious cost of setting up an efficient medical organization with the doctors, nurses and special personnel needed for staff. It is more prudent for business to divorce itself from direct contact with medicine, and confine efforts within the plant to a purely first-aid basis. This is particularly true in attempting to set up yearly examinations for executives. Companies worried about executive health have summarily ordered their personnel to appear for yearly examinations. In doing that, they place their collective foot in a hornet's nest. The fine line of "meddling" in personal affairs has doomed many well-meant executive health programs to dismal failure. In some cases it has actually disrupted the management organization.

THREE facts are clear: (1) executives feel more cooperative toward outside doctors than to "company physicians;" (2) examinations must be voluntary not compulsory; and (3) most important of all, conclusions must be held in complete confidence and given to the patient or the family physician, but not to the president of the company. Accustomed to the routine report, business has found the latter restriction hard to accept. Examinations in which the patient, apprehensive about his job, employs a "fifth amendment" attitude toward health questions, benefits neither the employee nor the company footing the bill.

How thorough should the examination be? An examination of the "whole man" is indicated. This does not imply a battery of tests in which the patient has the impersonal feeling of a guinea pig in a laboratory. Emphasis must be placed on the individual's physical, emotional and environmental well-being both on the job and in the home. Apart from organic disease, hurry, worry, personal and financial problems are the major cause of sickness. *Without a guiding hand, there are more*

people insecurely sick than securely well. Whether done by a clinic or, preferably, by an internist, the examination is ultimately a matter of counsel and clarification to the patient in cooperation with the family physician. Companies may prudently offer *diagnostic* procedures. Treatment, if indicated, is the personal prerogative of the patient.

It is logical and practical for business to sponsor an annual examination to promote efficiency and to foster health among employees. This is proved by the few management groups which have undertaken to pioneer this approach. Labor and management in cooperation with medicine may well form the number one team of the future. So united, it could effect savings, both financial and personnel, by the promotion of constructive health programs.

85 Park Street

You Really Do Need Breakfast

Five years of research has convinced a team of University of Iowa scientists that breakfast-skippers rob themselves of potential alertness and efficiency during the late morning hours, and that dieters are wrong if they think missing the morning meal is a practical way to lose weight.

The research was directed by Professor Tuttle, of the physiology faculty and Professor Daum, director of nutrition.

In one phase of the research, half of the subjects were placed on schedules which included the morning meal. The other subjects received the same diets, but the food was spread over the mid-day and evening meals, breakfast being omitted. After periods of two to four weeks, the two groups "swapped" schedules, the first then missing breakfast and the original "no breakfast" group receiving that meal.

Omission of breakfast placed the subjects at a distinct disadvantage in both physical and mental efficiency in the late morning hours. Omission of breakfast had no influence on weight.

People tend to eat as many calories in two meals as they would otherwise eat in three. Dr. Daum points out that many of the diet plans designed for weight reduction fail to provide an adequate breakfast, and that some of these plans virtually exclude the meal.

Small breakfast, large breakfast, and the "coffee only" breakfast were then studied. It was found that the small breakfast was inadequate. The large one detracted from the capacity of a number of the subjects to perform work. Coffee alone "exaggerated neuromuscular tremor magnitude."

Studies showed that 10 grams of protein was inadequate, that 15 grams was "on the borderline," and that 25 grams — which might be found in a meal containing cereal and milk or eggs and milk—was "entirely sufficient" for maintaining the blood sugar at a normal level during the late morning hours. Maintaining the blood sugar at an adequate level tends to prevent hunger and makes it possible to perform more efficiently in the late morning hours.

As a result of their findings, the research people believe the "best" breakfast is one which consists of the ordinary breakfast items and provides one-fourth of the total daily requirement of calories and protein. For example, a person who needs 3,000 calories daily should eat a breakfast which provides approximately 750 calories. The breakfast should contain 25 grams of protein. Such a person would find a breakfast adequate if it included three and one-quarter ounces of fruit juice, one ounce of cereal, two slices of bread, one tablespoon of sugar, one pat of butter and one pint of whole milk.

For persons who require a larger breakfast, the menu may be increased 150 calories with the addition of two eggs, or 180 calories with the addition of two eggs and two slices of bacon. If a smaller breakfast is needed, the menu can be reduced 165 calories if one-half of the milk is omitted. The research has shown that breakfast is an "economic necessity," and that people should manage their time in such a way that permits inclusion of an adequate morning meal in the eating schedule.

Morris H. Saffron, M.D.
Passaic

Psychosomatic Factors in Tension Dermatitis*

Highlighting the emotional component of skin disease, Dr. Saffron suggests that the dermatologist should practice some psychotherapy. He does not believe that training in psychodynamics is essential for this therapy. If only a single drug could be used, he recommends phenobarbital. The emotional backgrounds of certain dermatoses are explored.

The concept of the skin as a mirror of emotional disturbance is nearly as old as recorded history. The literature of antiquity abounds in references to the visible effects of fear, embarrassment, hatred and love. Solomon aptly asks in Proverbs: "Can a man carry fire in his bosom and his garments not burn?" Seneca insists that anger, no matter how well concealed, is invariably betrayed by the countenance; while the brilliant diagnosis of Erasistratus who discovered in the blushing face of his royal patient the true cause of his wasting disorder has been famous for centuries. Many additional allusions from classical and later authorities to the pallor, flushing and sweating by which the body reacts to the powerful stimulation of the emotions may be found in that mine of erudition, Robert Burton's *Anatomy of Melancholy*.

Shakespeare, with his profound insight into psychological matters, may be expected to contain many references of a similar nature: Hamlet's "O Shame! where is thy blush?" Desdemona's despairing: "Alas, why gnaw you so your nether lip? Some bloody passion shakes your very frame;" and again, "Mine eyes do itch; Doth that bode weeping?" are but a few examples. Lady Macbeth's "Out damned spot," and Queen Gertrude's "Black and grained spots" are often cited as dermal projections of a sense of guilt. Such familiar expressions as "white with rage," "sitting on pins and needles," "itching for a fight," "sweating it out," "thick-skinned" and "thin-skinned" are only a few which demonstrate that common folk-lore, at least, has never lost sight of the intimate relation between skin and psyche. In this connection it is interesting to note that the expressions "to chafe" or "to be chafed" so frequently used by our patients are derived originally from the French "chauffer," to make warm, to vex or to enrage.

With the rise of rationalism among the physicians of the Roman empire, the earlier constitutional theories of Hippocrates and his followers were discarded as being too vague for practical purposes. This is of some importance to our subject since Galen, who was destined to remain the great medical authority for over a thousand years, (although fully aware of the profound effects of the emotions on the body) preferred to seek for the explanation of skin disorders associated with pruritus in the excretion of some noxious substance, the product of faulty metabolism. This remained the standard theory of cause until well into the present period.

The rise of modern dermatology in the lat-

*Read before the Section on Dermatology, Annual Meeting, The Medical Society of New Jersey, April 18, 1955.

ter half of the nineteenth century was brought about primarily by revolutionary advances in cellular and organ pathology and bacteriology which came in rapid succession from the medical centers in Austria and Germany. Hebra and Kaposi of the famous Viennese school profoundly influenced the subsequent course of our specialty, not only by their enlightened classification of the various disorders of the skin, but also by their emphasis (I might almost add over-emphasis)on the importance of pathologic study as the decisive factor in determining the ultimate cause of any specific skin condition. Kaposi's unwillingness or inability to concede any importance to emotional elements is readily apparent. Thus while discussing generalized pruritus he says: "It is only towards morning that the disturbing sensations abate and quiet sleep follows, of too brief duration to give the patient, so sorely tormented, the requisite physical and moral refreshment. The most tranquil hours are those in the early morning. In the course of the day, more or less regular attacks, of unequal duration occur, either spontaneously or in consequence of some exciting cause. Among such may be enumerated bodily and mental excitement, mental influences of a sudden and unpleasant character such as anger, impatience, compulsory continuance in a particular occupation, or in a special locality, at the theatre, in company, the consciousness of the compulsory position, the fear even of an attack, the mere thought of the possibility of an attack and the inconveniences which must attend it in a strange place—mostly psychical influences, any of these suffice to excite itching, at first mildly, then more severely, and ultimately a thorough attack." Yet after this clear and enlightened description (which would satisfy any student of psychosomatic medicine today) Kaposi refuses to accept the inevitable conclusion of his own findings. He continues in his subsequent discussion of the etiology of generalized pruritus and of anogenital pruritus to admit frankly that he is at a loss to explain these entities on the only firm basis, namely pathology; and finally dismisses the "neurotic theory" as of minor importance.

The introduction in 1891 of the term "neurodermite" by Brocq and Jacquet, and the experimental studies of the phenomenon of bullae produced artificially under hypnotic influence resulted in a revival of interest in the entire subject of psychocutaneous disorders. Without going into a lengthy discussion of the history of these studies I should like to pay tribute to four Americans whose work has been of fundamental importance in this field. J. V. Klauder of Philadelphia and H. H. Hazen of Washington led off in 1925 with articles on emotional hyperhidrosis of the palms and soles, and pruritus vulvae, respectively. Klauder went further in a subsequent paper in which he insisted that the influence of the psyche was manifested more clearly in the skin than in any other organ of the body. Another Philadelphian, J. H. Stokes in a series of brilliant articles written during the nineteen thirties analyzed thoroughly the asthma-prurigo type of personality, which he found to be characterized by tremendous competitive drive, a deep feeling of insecurity and a characteristic unrest. Finally Becker of Chicago, basing his own theory on Warthin's concept of protoplasmic unrest, postulated an interrelationship between vasomotor instability, functional disturbances, and various allergic manifestations on the one hand with the neuroses and neurodermatoses on the other. This he illustrated in diagrammatic form. Writing during depression days, Becker also emphasized the etiologic importance of adverse social and economic factors in the rapid increase of the neurodermatoses.

We are all aware of the tremendous interest in psychosomatic medicine during the past decade sparked by the pioneer work of Flanders Dunbar. This has been encouraged by countless articles and books in the medical and popular press. Yet a few years ago when Madame Chiang Kai-Shek arrived in this country for the treatment of neurodermatitis, several doctors told me they had never even heard of this condition, and seemed unaware of the fact that continued emotional tension could produce a characteristic skin reaction. In December 1954, at the meeting of the Academy of Dermatology, I heard a panelist in a discussion group disparage "the new-fangled" tendency to hold 'disordered nerves" responsible for

pruritus ani. The conservative dermatologist with his gaze fixed firmly on externals is proving to be a reluctant convert to the psychosomatic concept. His position is becoming increasingly untenable in light of the recent findings of several psychiatrists and dermatologists with psychiatric orientation who have studied many patients with various skin disorders, using the specialized technics of their craft. The most recent and comprehensive exposition comes from the facile pen of the English psychiatrist Eric Wittkower whose training in both disciplines has enabled him to clarify the semantics of psychocutaneous medicine for those dermatologists who, like myself, have had no formal training in psychiatry. His latest monograph "Emotional Factors in Skin Disorders," written in collaboration with a dermatologist, Brian Russell, and several other psychiatrists, is destined in my opinion to become a classic. Other recent writers for whose works I am grateful are S. H. Zaidens and P. F. D. Seitz. An article by the latter which appeared in the *Archives of Dermatology* in 1952, also written in collaboration with a dermatologist, James S. Gosman, has proved valuable in coordinating certain thoughts of my own. It was also useful in helping me determine the type of case suitable for treatment by a dermatologist, and the simple procedures to be followed.

Until recently one of the obstacles in the attempt to clarify the physiology of cutaneous disease has been that we could not explain the regulatory mechanism of the sebaceous glands, which have no known autonomic innervation. The "general adaptation theory" of Hans Selye views stress as affecting large areas of the body, and directly influencing certain tissues. This suggests that a humoral rather than a neuronal connection may account for the relation between physiologic stress and the seborrheic state which has been noted by observers in recent years. According to Selye "Alarming stimuli of a neurogenic or psychogenic nature are particularly potent activators of the pituitary, adreno-corticotrophic function and produce rapid and intense alarm reaction." Among these stimuli he includes rage, anger, fear, and anxiety. If this theory of prolonged stress resulting in chemical or hormonal imbalance within the body can be substantiated it should prove helpful in explaining why ACTH and cortisone have been found to be of such benefit in many disorders of the skin heretofore considered refractory to treatment. Selye also reverts to a Hippocratic emphasis on the individual's "terrain" or constitution. His theory has provided a useful approach to physiologic problems of psychosomatic disease. In the office I have found the stress theory of value in trying to explain to a frantic patient the cause of an intractable itching. Some patients will resist vigorously the idea that they are "nervous." This, to the layman, frequently has the implication of a mental disturbance. But most patients accept the thesis that the skin disorder may be the result of the prolonged tension and stress of daily life and of their inability to relax properly. Since the patient's cooperation must be won in these cases, the use of an acceptable phrase is a matter of no slight importance.

WHAT conditions are accepted as being, in some manner, of psychogenic origin? Most observers include recurrent herpes simplex, recurrent dyshidrotic eruptions of the palms and soles, and lichen planus. About 15 years ago I described in the *Archives* the only known instance of four cases of lichen planus in a single family. It was the study of this group of intelligent, sensitive, but highly tense individuals that first impressed me with the tangible cutaneous sequelae in prolonged emotional disturbance. We have all observed that the dissemination of a hitherto quiescent psoriasis or seborrheic dermatitis can frequently be traced to some depressing set of circumstances in the individual's routine which has upset the emotional balance and set into play the "itch-scratch" mechanism. We are also familiar with the emotional effect of acne on an adolescent. This effect is much more noticeable in some than in others, depending on the basic mental outlook. In other words the pattern in which the individual reacts to the problems of life in general will influence the reaction to his acne and will determine whether there results, as Wittkower and Russell so

aptly phrase it "a vicious circle of mind-body and body-mind aggravation."

That emotional factors influence the disappearance of warts is well known. I believe that similar factors are involved in their propagation as well. I think that the wart "virus" flourishes particularly in young people who show hyperhidrosis and other evidence of vasomotor lability. It is not surprising, therefore, that one frequently observes an occasional wart or two, sometimes of long-standing, in adults who come for treatment of some other variety of neurodermatosis.

As for alopecia areata which I also consider to be a response to emotional stress, I am in agreement with Harry L. Arnold, Jr., who obtained his best results by disregarding local therapy completely and by following a program of reassurance in which he minimized the importance of the disorder and offered the patient an optimistic prognosis.

URTICARIA

Although urticaria has been the subject of intensive studies by allergists and internists alike we all know that in many instances of both the acute and the chronic recurrent variety it is impossible to determine the specific trigger mechanism. Even after the individual has been placed in a dust-free, feather-free cell, and placed on one of Dr. Rowe's tasty diets of rice and milk; and, if a woman, deprived of all her cosmetics, the urticaria has a way of continuing merrily on. In cases of this sort attention paid to the habits, worries and family life of the individual will often prove rewarding. A policeman, aged 26, married, in perfect health, with no previous allergic history came to me because of the sudden onset of severe angioneurotic edema of the lips, eyes and face. I treated him with conventional methods, including calcium, antihistamine, diet and cortisone with little or no improvement over a period of two months. One day when the face was again puffed out to the size of an egg I questioned him a bit more thoroughly than on previous occasions. He told me that about six months earlier he had been in an accident while driving a motorcycle in the course of duty. For some time after he was permitted to drive a police car, but being one of the younger members of the force he was eventually ordered to return to the motorcycle to which he had developed a definite aversion. The urticaria appeared precisely at this period. Fortunately in this case I was able to recommend a change of assignment. The urticaria disappeared as abruptly as it had come and has never since recurred. Another instance concerns a young man who suddenly developed an acute urticaria on being told that his pregnant wife had been found to be Rh negative two months before delivery. No other cause for the eruption could be found. The sense of frustration which Wittkower mentions as one of the constant findings in patients with urticaria was apparently intensified by the position of conflict with their environment to which these men found themselves subjected.

ROSACEA

Rosacea is a fairly common condition in middle aged women, characterized by a more or less permanent erythema of the "flush areas" of the face and frequently accompanied by an acneform eruption. Because of the retiring nature of these people, many mild cases do not come to the attention of the physician. Patients with rosacea readily report that from childhood they have had a tendency to blush at the slightest provocation. They have noticed that the redness is invariably aggravated during periods of emotional stress. Of 28 cases in my series only three were men; of the 25 women only 9 were married. Two typical cases, somewhat similar in general pattern are:

One woman, single, aged 38, had been a bookkeeper for many years in a large office. By virtue of seniority, she had been offered the position of supervisor of personnel. After lengthy reflection and inner turmoil she finally decided not to accept the new assignment, because the change would necessitate her meeting with strangers during the course of the day. Nevertheless, she suffered an acute flare-up of her rosacea simply from thinking over what she had escaped, thus proving that Longfellow was right when he said that " a thought often makes us hotter than a fire."

The other case was that of a school teacher, aged 29, who from the time of her entry into the school system had been engaged in research which necessitated only the briefest contacts with strangers. Because of the teacher shortage she was assigned to one of the upper grades in grammar school and promptly developed an extensive outbreak of rosacea, involving the entire face, forehead and upper chest.

Many patients with rosacea have a definite feeling of inadequacy and depend greatly on the good opinion of others. I find that they can be benefitted considerably by encouragement and reassurance. In my own series, digestive symptoms did not seem to play an important part. Although correction of diet, removal of foci of infection and local therapy should not be neglected, a lasting improvement depends on giving the patient insight into the nature of her condition. A conscious effort to control the blush mechanism is often rewarded by gradual improvement and eventual recovery.

TENSION DERMATITIS

DRY TYPE: In adolescent and adult patients, this is evidenced by circumscribed areas of lichenification, involving especially the flexor surfaces of the extremities, the eyelids and the neck. They frequently give a history of "allergic" manifestations such as atopic dermatitis in infancy or early childhood. Some do occur with no antecedent dermatologic history. The characteristic intense pruritus results in excoriations which Seitz feels are "more fundamental symptomatically" than the pruritus itself. In other words the characteristic manner in which the patient reacts to the itching is in itself of clinical importance in making the diagnosis. Pruritus is a symptom of many dermatoses. But it is only in the patient whose emotional imbalance has actually precipitated the symptom complex that there results those pleasurable sensations from rubbing, picking and scratching the skin, which in turn bring about the indefinite continuation and perpetuation of the dermatitis. Throughout life they tend to react violently to any specific situation which involves change from routine patterns of existence and the loss of accustomed support. The restless, hostilely-aggressive child may use an atopic dermatitis as a weapon against the parents, especially the mother. I have seen numerous cases where the arrival of a second child in the family has precipitated an attack of itching and scratching in a vain effort to regain the center of the household stage. A fourteen year old youngster, an only child with no previous history of skin trouble, developed a severe and resistant cubital space dermatitis a few weeks before his anticipated departure for military school. In this case, the threat of loss of parental support contributed to the outbreak, especially since he had been taught by his father to keep his emotions "under control."

Many of these patients who have studied over a long period of time to conceal their emotions are either reluctant (or actually unable) to go back to the position of giving vent to them. Frequently they are aggressive, ambitious people who are constantly competing mentally with others. Often above average in intelligence and adaptability they are outwardly calm and, among their intimates they enjoy a reputation for dependability in times of emergency. At first one may encounter some resistance to the suggestion that "nervous tension" is causing the skin trouble. But once convinced, they cooperate readily and show their usual keen interest by carrying out faithfully any procedure suggested to encourage relaxation.

EXUDATIVE variety: This includes such entities as eczema of the hands, the so-called nummular eczema, and the Sulzberger-Garbe syndrome. Schneider and Kesten believe that emotional conflict is of prime importance in the development of the latter condition, and that intensive psychotherapy may be required. Most of my own cases of hand eczema and of nummular eczema have had an underlying stress background which is primary. The "trigger mechanism" which may be soap, oil, or other irritant is of minor importance and may vary from time to time with recurrent attacks. Thus, eczema of the hands in a recently-delivered mother is not simply an example of soap and water dermatitis induced by overexposure. It is a form of tension dermatitis

brought to the surface by additional responsibility. With a simple sedative and antihistamine combination internally, and no local medication of any sort I have been able to effect recovery in a number of these cases, without changing the soap or detergent which is so often blamed for this troublesome condition.

The ano-genital pruritus syndrome is one commonly encountered in practice. Many proctologists and gynecologists agree that when all the hemorrhoids have been injected, all the fissures and fistulae removed, and all the vaginal discharges properly cleared, there still remain a large group of unhappy, itching people. Psychiatrists are not unanimous as to the exact nature of the conflicts which produce this syndrome. Some ascribe it to "disturbed eroticism." Others stress the importance of suppressed hostility or unrecognized aggressions. In spite of these disagreements, psychiatrists concur in the need for an assessment of the total personality of the patient to determine the intensity of the psychoneurotic disturbance, and the indication for formal psychiatric treatment.

THE time has arrived when we dermatologists must give more thought to the total life situation in which our patients find themselves. Many of us confine our attention solely to the entity which appears in the skin. None of us would neglect to do blood counts for suspected anemias or biopsies for persistent growths of indeterminate nature. Why then should we neglect the study of the emotional environment of the patient, or an estimate of the emotional content of the cutaneous reaction? It is not so long ago that peptic ulcer was explained solely on the basis of dietary indiscretion, excessive acidity, cigarette smoking, and other somatic factors. Today the emotional implication of an ulcer flare-up is recognized by doctors and patients alike.

That the dermatologist can and should practice a limited type of psychotherapy is the opinion of all writers who believe that the skin is an organ of expression. To do this satisfactorily he must have the time and the inclination for it. Although some formal training in psychodynamics would naturally be of value, I do not personally consider this essential. It is essential, however, to be a good listener, to be sympathetic and encouraging without getting too deeply involved in the patient's problems.

The physician must first consider the patient as a whole, entirely apart from his dermatitis, and try to understand how he reacts to life situations in general. Furthermore he must comprehend the need for affection which is at the root of so many itch-scratch type reactions in childhood, in adolescence and throughout life. He may have to explain this mechanism to a misunderstanding parent. He may have to convince a zealous housewife who keeps her house spotlessly clean that to be overly conscientious in such matters may indicate a repression of hostile emotions. This in turn may produce a reaction in the skin. It is surprising to note how often the patient is himself aware of the essential nature of the malady and will suggest nervousness as the cause. One woman told me that she would itch and scratch as soon as she learned of the impending visit of a difficult mother-in-law. By the time her husband's mother arrived she was pretty sure to have a few patches on her arms. A similar cause was suggested in another case by a young woman who, reacted in the form of severe herpes of the lips. The dermatologist should, of course, never try serious psychoanalysis, leaving such procedures for those trained in it.

Dr. Louis Le Bel, my first mentor in dermatology and incidentally, the first chairman of this Section, used to tell how at the Vanderbilt Clinic he coined a term "dermatitis mystificata" to cover those conditions to which no one could assign a definite cause. Many recalcitrant pruritic eruptions which resist all our efforts in the way of local therapy, x-rays, vaccines and allergy-free rooms can be helped immeasurably by an attitude of support, understanding and encouragement.

In the limited time alloted to this paper I have been able to cover the subject only in a very summary manner. But when, in 1949, a hospital like St. John's of London (which is devoted entirely to diseases of the skin) could report that in 45.2 per cent of all cases ad-

mitted to the clinic, emotional factors were of significant etiologic importance then the selection of this topic for even a brief discussion seemed well justified. Some persons undoubtedly will take the position that many of these impressions are too subjective in nature and are not capable of scientific corroboration. This is true, but only to a degree. When we apply 3 per cent ammoniated mercury to an impetigo we can anticipate a fairly constant effect; on the other hand the results we obtain in our approach to the tense, emotionally distraught skin patient will depend in large measure on the personality of the dermatologist, the air of calm conviction that he displays in the truth of his beliefs, and finally in his ability to convey this insight and calmness to the patient. Perhaps it will best define my own position to say in conclusion that if I were forced to limit the medications at my command to a single drug I should ask without hesitation for phenobarbital.

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DISCUSSION

JOHN W. KINLEY, M.D., Summit: The eyes are described as the mirrors of the soul. The skin is a canvas on which the psyche reveals itself. The skin is the borderline between the individual and his environment. In 1927, W. T. Sack pointed out that the skin is an especially favorable area for the study of psychosomatic relationships—particularly since there appears to be no voluntary innervation.

I would like to comment just a bit further on the difficulties encountered in attempting to identify the food or irritant which acts as the trigger mechanism in many instances of urticaria. In the allergic dermatoses, "the threshold of allergic response may be raised or lowered at a given time by the state of emotional tension." A patient may react to an allergen at one time and not at another. Flanders Dunbar presents two examples of this. One was that of a patient who reacted to a certain type of food at home but not on vacation, even though the food was obtained from the same source. Another was that of a child with asthma and dermatitis whose attacks, while at home, were aggravated by ingestion of fish. In a sanitarium, ingestion of the same fish failed to produce a reaction in the child.

Another, and perhaps more direct, example of the role of the emotions in the causation of urticaria is Naber's case of a 45 year old woman who suffered from severe attacks of urticaria every evening for 10 years. All general medical and dermatological treatments were ineffectual. Investigation showed that she was annoyed that her brother came to her home every evening so that she was never able to be alone with her husband. After the connection had become clear to her she no longer had urticaria.

Kierland and Walsh in 1950 reporting on psychoanalytic contributions to the understanding of psychosomatic dermatology stated, "The skin becomes through erotization, an unconscious medium of hostile, masochistic and exhibitionistic trends in the personality. Repressed genital sexuality may be replaced to the skin with scratching sometimes representing a masturbatory equivalent."

Seitz, Gossman and Craton in 1953 examined 35 intelligent and cooperative patients with localized neurodermatitis. Patients with neurodermatitis gave a higher number of intropunitive (self-punishing) responses than were obtained from controls and these patients tended to express aggressiveness masochistically.

The psychosomatic approach is a personal approach to illness in which as much interest is taken in the person as in the morbid process about which complaint is made. Each patient is a personality with an attitude of mind and a way of reacting to life all his own; he is not just a "case" of asthma or dermatitis.

There is, as Dr. Saffron has stated, general agreement that a dermatologist can and should practice a limited amount of psychotherapy. Seitz and Gossman a few years ago expressed the opinion that the dermatologist who wants to do psychotherapy must enjoy helping people, must be able to sit quietly and listen comfortably, must not become excessively anxious in doing this kind of work—and must be relatively free from serious emotional problems himself. The physician should not strive primarily for insight in his patient, although he may provide mild ventilation and catharsis in connection with current conflicts. If he finds evidence of psychosis or severe psychoneurosis, for example, patients suffering from delusions of parasitosis or acarophobia, a dermatologist will be well advised to refer his patient to a psychiatrist.

The general qualifications required of the physician have been adequately covered but I think a few more words regarding the qualifications for the patient are in order. For example his illness should be of not too long standing; his past history should be one of relatively good social, occupational, marital and sexual adjustment; that his emotional conflicts are predominantly current.

Provided that he has an understanding of fundamental psychiatric principles the physician or dermatologist who first examines a patient should give both physical and emotional treatment. Giving the patient better understanding and emotional relief through reassurance and encouragement may be all that is necessary to cancel out the psychic factor in his psychosomatic illness.

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The Effect of Hydergine* on Peripheral Vascular Disease

In the search for an effective peripheral vascular dilator the possibility of Hydergine® has been considered by many students of the subject. Dr. Frank and his colleagues here give a cautious and conservative report which suggests that the drug has a fifty-fifty chance of helping the patient.

During the past decades many vasodilating drugs have been proposed for the treatment of peripheral vascular diseases. Most of these have been disappointing. For the past four years we have been evaluating Hydergine* in peripheral vascular diseases at the Peripheral Vascular Clinic of Jersey City Medical Center. The purpose of this paper is to report our experience with Hydergine* in the management of peripheral vascular diseases.

In 1943 Stoll and Hofmann,[17,18] showed that hydrogenation of the readily-reducible bond of lysergic acid of the ergot resulted in well-defined compounds. Thus an entirely new group of substances, dihydroergocornine, dihydroergocristine, and dyhydroergokryptine was made available. Subsequently, Rothlin[15] demonstrated that these new hydrogenated alkaloids are less toxic. The process of hydrogenation produces a preparation with characteristics quite different from those demonstrated by the natural ergot alkaloids. The action of Hydergine* is essentially vasodilator and extensive pharmacologic study indicates that this is mediated centrally through dampening effect on the vasomotor center, complemented by latent adreno-sympathicolytic activity.[15,16]

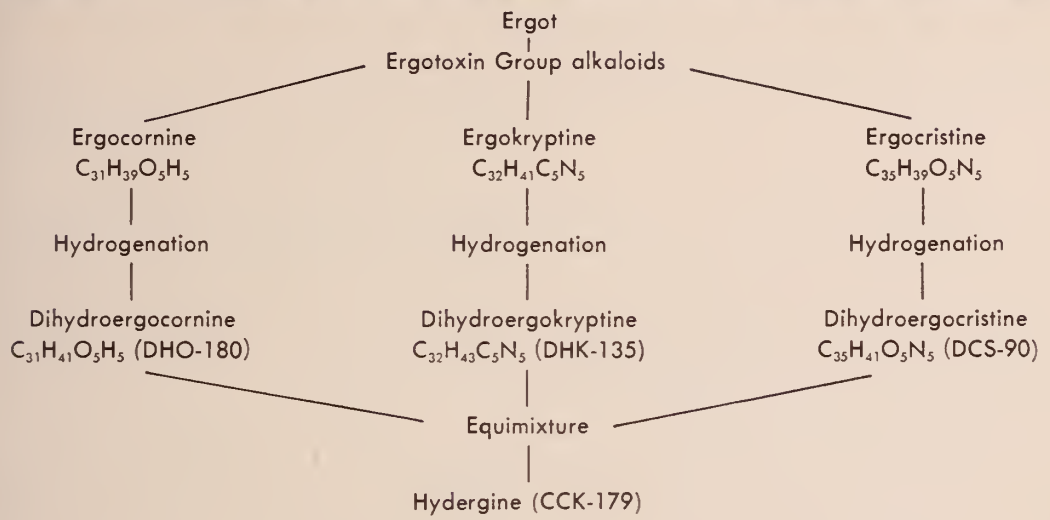
Fifty patients (41 male and 9 female) with peripheral vascular diseases were treated and studied at our clinic from 1950 throughout 1953, to determine the clinical effectiveness of Hydergine.* All of these patients had previously visited the clinic. Most had been previously diagnosed and evaluated by objective procedures including oscillometry and skin temperature determinations. The following describes the group:

	No. of patients	Average age
Arteriosclerosis obliterans	39	62.6
Thromboangiitis obliterans	6	44.8
Raynaud's disease or syndrome	4	38.2
Rt. femoral art. or embolism (R.H.D.)	1	44.0

All treated cases except the right femoral arterial embolism, were "chronic." None had responded to previous therapy nor to the various conservative treatments—such as diet adjustment, personal hygiene, proper clothing, restricted activity, whiskey or discontinuance of smoking. Each patient received an outline describing the administration of the Hydergine.* Each took part in an oral explanation of proper administration. The Hydergine* tablets were administered sublingually to 12 patients and rectally to 38 patients. Dosage varied from 0.5

*Product of Sandoz Pharmaceuticals, Hanover, N. J.

GRAPHIC ILLUSTRATION OF THE CHEMISTRY OF THE HYDERGINE COMPOUNDS



to 2 milligrams three to four times daily. Duration of treatment varied from six months to three years. Each patient was "checked" or examined in the clinic every four to six weeks. To evaluate the effectiveness of this treatment, the following criteria were used: walking tolerance, (intermittent claudication) surface temperature, skin color, rest pain, cramps, ulceration, gangrene and pulsation of the peripheral arteries. The total clinical response was designated as good, fair and poor.

A *good* response indicates complete relief of all symptoms. *Fair* response designates some degree of improvement. *Poor* means that the patients' condition remained essentially unchanged or became worse while under treatment.

The following table summarizes the response to Hydergine*.

	No. of Patients	Results Good	Fair	Poor
Arteriosclerosis obliterans	39	7	11	21
Thromboangiitis obliterans	6	2	1	3
Raynaud's disease or syndrome	4	1	1	2
Rt. femoral artery embolism (RHD)	1	1	0	0
	50 (100%)	11 (22%)	13 (26%)	26 (52%)

Thirty-nine patients with arteriosclerosis were evaluated and 18 or 46 per cent showed a good or fair response from this therapy. When complications such as diabetes mellitus, arteriosclerotic heart disease, coronary occlusion, were present, the response was not as favorable. This is summarized below:

Complications	No. of Patients	Results Good	Fair	Poor
Diabetes	10	3	1	6
A.S.H.D.	7	1	0	6
Coronary occlusion	3	1	0	2
Total	20	5	1	14

The following table presents the results according to age range:

Age	No. of Patients	Results Good	Fair	Poor
30-39	3	2	0	1
40-49	8	1	3	4
50-59	7	2	0	5
60-69	24	5	9	10
70-79	8	1	1	6
Total	50	11	13	26

Several patients reported side effects such as flushing, dizziness and mild headache. Only one asked to have the medication discontinued. Other investigators,[1,3,5,12-14,20,21] have reported stuffiness of the nose, slight headache, fatigue, thirst, hunger, nausea, vomiting, epigastric

pain and bradycardia, particularly with the parenteral form of Hydergine.* We did not use this route of administration. However, side effects with Hydergine* have been few, and when they did appear, they were mild.

COMMENT

To evaluate the clinical effectiveness and practical usefulness of Hydergine,* we studied it in patients with chronic peripheral vascular diseases for six months in some patients and up to three years in others. Symptoms were difficult to evaluate because of chronicity, multiple lesions, emotional state and mental conditions. Hydergine* has a fairly marked effect upon cerebral circulation (Weigelin,[20] Popkin,[12,13] Hafkenschiel[3] and McCall.[9]) Subjective complaints of these patients could, therefore, be masked by the feeling of well-being produced by the effect of Hydergine* upon cerebral circulation. Thus we evaluated very carefully their improvement and/or response with frequent checks at the time of each visit until their complaints and/or improvement became stabilized.

Several investigators since 1949 have published their experiences with Hydergine* in peripheral vascular diseases. The following table summarizes their results.

Authors	No. of Cases	Results Good	Fair	Poor
Ehren [1]	88	51	22	15
Fuschig [2]	103	50	38	15
Eichler [4]	59	32	0	27
Kappert [5,6]	118	67	35	16
Krischek [7]	45	28	4	13
Nieth [10]	70	34	18	18
Osten [11]	61	33	18	10
Roberts [14]	72	19	36	17
Popkin [12,13]	250	150	0	100
Total	866	464	171	231
	100%	53%	20%	27%

We found a great deal of discrepancy in these reports between the groupings; good, fair and poor. In the above series these authors obtained 53 per cent good, 20 per cent fair, and 27 per cent poor. We obtained 22 per cent good, 26 per cent fair, 52 per cent poor. Luke, *et al.*,[8] although skeptical about Hydergine* because of the disappointing results in patients when other vasodilating agents had been used, reported that, for intermittent claudication 80 per cent of the patients were "slightly to greatly improved." This seems to be better than our results. The poorer response we obtained from Hydergine* may be based on two factors. (1) We administered the medication sublingually or rectally, whereas several of the above investigators administered the Hydergine* parenterally or as a combination of the parenteral and sublingual forms. (2) We were very strict in our evaluation of the patient's symptoms or response. We found evaluation in peripheral vascular disease to be an extremely difficult task.

None of the present therapeutic agents are completely satisfactory for the treatment of peripheral vascular disease. Since our "good and fair" response to Hydergine* was approximately 50 per cent we believe it warrants trial as a practical treatment for conservative therapy.

SUMMARY

1. Hydergine* was administered sublingually or rectally to 50 patients who did not respond previously to different forms of treatment. These patients were observed every four to six weeks for six months to three years.

2. Of thirty-nine patients with arteriosclerosis obliterans, 18 per cent showed a good response; 29 per cent fair and 53 per cent poor. In 6 patients with Buerger's disease, 34 per cent good, 16 per cent fair and 50 per cent poor response was obtained. With Raynaud's disease 25 per cent good, 25 per cent fair and 50 per cent poor response was obtained.

3. One may hope for a good response from Hydergine* in peripheral vascular disease, but one cannot expect a dramatic recovery.

180 Bowers Street

A list of 20 citations and references appears in the authors' reprints

Arthur W. von Deilen, M.D.
Camden

Early Treatment of Head and Neck Injuries*

Because of his concern with more advanced injury, many a physician has failed to keep up-to-date his knowledge of first aid. Dr. von Deilen here offers a few exceedingly practical tips on the early treatment of face and neck injuries.

The importance of correct early treatment in injuries to the face and neck cannot be overemphasized. In the solution of some of these problems, the golden moment is the one when the patient is first seen in the accident room. Dazed and perhaps semi-conscious, small procedures can be done then without too much anesthesia. Local anesthesia can be used if necessary. These manipulations, quickly done, can sometimes change the outcome of a case by restoring facial contours which would be impossible to correct at a later date. If this opportunity is neglected, the cerebral complications usually suffered by the patient will prevent any formal procedure for correction under anesthesia for some time, perhaps ten days or two weeks. In that time the soft structures will have shrunken, and when bony structure has been fractured, enough adhesions will have formed to prevent future complete reduction.

Of prime importance in the emergency handling is the treatment of shock, arresting of hemorrhage, and the establishment of a permanent adequate airway if indicated. Plasma or blood should be given, and a tracheotomy done if there is the slightest doubt of the patency of the airway. When the lower jaw is broken bilaterally, the retrodisplacement of this part will let the tongue fall backward into the throat and embarrass respiration. Rather than thus endanger the patient, a tracheotomy should be performed immediately.

When the patient has stabilized somewhat, all lacerations should be pulled together, roughly and quickly if the patient is still in bad shape; or more carefully if time is not too much of a factor. All slice cuts should be trimmed until the flap is about 1/8 of an inch short all the way around so that when the wound is closed, the flap will be put under tension and be pulled out. This will help prevent "lumping up" as healing progresses and scar tissue forms under the thin mass of the flap. Wounds penetrating through and through into the mouth should be closed carefully on the skin side, and loosely pulled together on the inside, to permit drainage. Usually these wounds are caused by teeth being pushed through the tissues. They are likely to become infected. All tongue wounds should be just pulled together and not sewed tightly. I use Number 3 black silk for all the closures of the skin, and Number 3 chromic catgut for the deeper tissues. I do not find that the stitch scars are any worse when healing is complete, if this size silk is used rather than Number 4 or 5. Number 3 is certainly easier to put in and take out. All foreign material, such as glass, road dirt, powder marks, oil debris, and so forth, should be removed, if the patient's condition permits, by scrubbing

*Read before the General Session on Surgery at the Annual Meeting of The Medical Society of New Jersey in Atlantic City on April 20, 1955.

or other means. The minimum of actual debridement should be done.

THE two injuries that cause the most deformity and are the hardest to correct later, are fracture and displacement of the nose and fracture and displacement of the malar bones. These may occur together or separately. Fracture of the malar bones may be bilateral. Concurrent fracture of the jaws, either upper or lower, or both upper and lower may be treated later if desired. Usually the wiring of teeth is not included in these emergency procedures. Diagnosis is established by disturbance in occlusion of the teeth, pain and inability to bite.

The nose may be squashed flat or torn loose from the face. In nasal injuries, when the nose has been subjected to severe trauma, there is usually comminution of the nasal bones with a lowering and widening of the nasal bridge. This will occur even if the nose is torn loose from the face and is hanging by a pedicle. In either case, after necessary repairs have been made, the nose should be packed with vaseline gauze. This may be wrapped around a rubber catheter if desired. It will promote nasal breathing, tend to elevate the nasal bones to their former position, and prevent contraction of the soft tissue. Otherwise, the nose will have no shape, and as healing progresses, the soft-tissue-cover will shrink to fit the lowered nasal framework and the patient will develop a bad saddle nose. The nasal dorsum will be difficult to raise at a later date because of the scar, the diminished blood supply and the tight-fitting soft tissues. Progressively, pieces of preserved cartilage will have to be laminated into the saddle area many different times to stretch gradually the overlying skin and raise the nasal contour. This contour can never be raised completely, and the patient will always have a definite nasal deformity. When packing the nose, do not dilate it too much. After the first dressing is changed, say in a week or so, a smaller vaseline pack can be inserted, and the nose will shrink to it. If there is any doubt as to whether the patient will get enough air through the nose and mouth due to packing or fracture, a tracheotomy should be done.

If either or both of the zygomatic or malar bones are displaced into the maxillary sinuses, or the infraorbital margins are depressed with changes in the orbital floor, try to elevate the bones into their former positions, and so reposition the orbital contents. These bones, due to their many facets of attachment, become firmly fixed in their new positions in a short time. It will be almost impossible to reduce and reposition them entirely at a later date. Reduction is easily and quickly accomplished in most cases immediately after the accident by slipping a Kelly hemostat into the mouth behind the zygomatic arch and pulling upward and outward. The replaced bone will usually stay in place by the engagement of its broken edges. If this reduction is not done, the prominence of the cheek will be gone, the infraorbital margin flattened, and vision impaired due to displacement of the orbital contents. Diagnosis of fracture and displacement can usually be made by palpation of both infraorbital margins simultaneously, through the swelling. This diagnosis can be verified by x-ray, if time permits. Both the depression of the arch, and the depression of the infraorbital margin produce a severe cosmetic deformity which is avoidable in most cases.

IN the avulsion of tissue, all flaps should be replaced and tacked in place, even if the pedicle is small. No attempt should be made to sew them carefully in place as anything that will embarrass the blood supply should be avoided. If a portion of the lip or cheek has been gouged out, the wound can be treated by sewing the mucous membrane to the skin at the wound edge, with a later more definitive repair in mind. If a portion of one lip has been removed, a section from the other lip might also be rotated into the defect by means of a direct flap shift, as in the Abbe-Estlander procedure, or perhaps by a simple V closure of the lip structure. In ear injury, if a portion has been lost, the raw surface of the remaining part can be sewed into an incision in the post auricular skin which has been designed to receive this edge. This will prevent any

contraction, and preserve the remaining portion of the ear for future reconstruction.

Surface avulsion of tissue can be covered by split-skin grafts, or areas can be filled in by the shifting of local flaps. The less manipulation of the tissue done, the less chance of further embarrassing the already deficient blood supply.

A further word about the traumatic tatooing of the skin with foreign material, such as road dirt or gravel. An attempt should be made, if the patient's condition permits, to remove these foreign substances in the accident ward, by scrubbing and picking out particles.

If these few quick procedures can be done immediately after the accident without harm to the patient, the reconstructive problem will be greatly simplified for everyone concerned.

530 Cooper Street

The Care of Moles

Writing in the August 1955 Medical Annals of the District of Columbia (23:308), Chapman and Kloop make some observations on the common mole. They point out that recognition of melanoma is difficult by simple inspection. An accurate diagnosis is possible only postoperatively. In considering the removal of a "mole" the following points may be weighed: Not all pigmented skin lesions are nevi (moles). The obvious exceptions are freckles, hemangioma, angioma, patchy vitiligo, and seborrheic keratosis. The last-named is often deeply pigmented and cannot be classified by clinical observation alone. They should be viewed with suspicion.

Having eliminated these conditions, the question of surgical removal revolves around the following indications:

Any nevus should be surgically removed if it:

Bleeds or has a discharge
Is subject to frequent irritation
Shows enlargement or deepening of color
(Exceptions: Slight enlargement and deepening of pigmentation can occur during pregnancy, hormonal therapy, and the menarche.)

Patients should be questioned concerning the above and their opinion accepted. Rules for removal do not imply that the physician will personally determine by repeated examination if the above changes have occurred. There is no place for a watch-and-wait attitude in determining what course to follow.

Carbon Disulfide Poisoning Can Fool the Doctor!

Two cases of an uncommon chemical poisoning with such "interesting and bizarre" effects as stomach ulcer and mental depression are reported in the October 15 J.A.M.A.

Persons suffering poisoning by carbon disulfide—used in making rayon or artificial silk—may appear to have chronic alcoholism, lead poisoning, brain tumor or multiple sclerosis. Symptoms include headache, weakness, nausea, inability to concentrate, forgetfulness, unsteadiness, double vision, impotency, temper outbursts, numbness of the hands, and anemia.

Present standards of safety — based on the air concentration of carbon disulfide vapor—are now too low and should be raised, suggest these authors. Poisonings could be prevented, they said, by adequate ventilation of rooms where the chemical is used.

Early diagnosis also is essential, because many advanced cases of carbon disulfide poisoning do not respond to treatment. Some of the symptoms in the two reported cases had appeared 10 years before their cause was recognized.

Making the report in the October 15 Journal of the American Medical Association are Dr. Irving R. Tabershaw, director of the division of industrial hygiene in the N. Y. Labor Department, and Dr. Morris Kleinfeld of the medical division of the same office.

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Drug Therapy in Psychiatry and Neurology*

Medical and Pharmacologic Aspects

Time was when sedatives were the principal therapeutic crutches of neurologists and psychiatrists. Today the analeptic medications, as well as drugs of more general application, give the psychiatrist and neurologist a richer inventory of therapeutic tools.

In psychiatry and neurology, the medical and pharmacologic aspects of therapy might be considered synonymous with the effect of drugs on the brain. A little thought, however, makes it apparent that practically *all* drugs affect the brain to some extent, directly or indirectly. Thus it is possible to describe a spectrum of degrees, or directness of effect, of drugs on the brain ranging from the psychic benefit of a placebo to the rather specific chemical effect of an anticonvulsant given for epilepsy.

The point is illustrated schematically below:

1. *Placebos*—or drugs whose effect is purely psychic.

   Example: lactose placebo.

2. *General Medications*—or drugs which relieve distress, fatigue, or general illness.

   Examples: sulfonamide for cystitis due to E. coli, or Prostigmin® for myasthenia gravis.

3. *Medications for Body and Mind*—or drugs which help the general body metabolism and also that of the central nervous system.

   Examples: thyroid for myxedema, nicotinic acid for pellagra.

4. *Drugs acting primarily on the Central Nervous System* — or drugs whose action can be traced either by objective or neuropsychiatric methods to have their chief action on the brain or spinal cord.

   Examples: phenobarbital for epilepsy, dextro-amphetamine sulfate for depression or narcolepsy.

Placebos are assumed to be inert except for their effect on morale and encouragement of the patient to try to do as well as he can under the circumstances. *General medications* have all the psychic value of placebos plus a demonstrable value on a disease process. *Metabolic medications restore the function of body and of mind*; they have value as placebos and general medication as well as a specific effect on the brain. Finally we come to *drugs which have a demonstrable effect on brain tissue*, though this does not necessarily mean they do not have other effects on the body also.

Placebos are deserving of special mention. Consider first some conditions in which somatic lesions are usually demonstrable. In two recent studies on the use of heparin for an-

*Read April 19, 1955 at the Psychiatry and Neurology Section, Annual Meeting, The Medical Society of New Jersey. The authors are Assistant Medical Director and Vice-president in charge of Clinical Research (respectively) at Hoffmann-La Roche, Inc.

1. Chandler, H. L. and Mann, G. V.: Heparin Treatment of Angina Pectoris. New England Journal of Medicine, 249:1045 (December 1953).

gina pectoris[1] or for intermittent claudication,[2] the experimenters gave either the agent or a placebo of sterile saline intravenously, twice a week. Of the patients with angina, 11 out of 13 reported benefit from the placebo; and their average weekly number of nitroglycerine tablets used fell from 45 at the start to 26 after one week to a rather stable level of 16 after 100 days. The patients with intermittent claudication were tested by the length of time they could walk at a standardized speed on a treadmill. One man's walking time increased from 3 minutes to 13 minutes after 13 weeks of the saline injections. In both studies the patients' improvement was striking, but no greater with the agent than with the placebo.

These examples indicate how necessary it is to have controls in any study of the effect of drugs on the symptomatic aspects of disease, whether somatic or involving only the nervous system, and re-emphasize the importance of the *physician himself as a therapeutic agent.*

A question which is frequently asked is: "What percentage of improvement would be obtained from a placebo alone?" Results will depend on the personalities of patients and physicians and the nature of the conditions treated. Two recent papers give us a hint as to what we may expect. Wolf and Pinsky[3] studied 31 tense and "nervous" patients by the double blind method. The agents used were a placebo and a well-known muscle relaxant. The results from the two were about the same, about 30 per cent said they were better, about 10 per cent said they were worse, and about 60 per cent reported no change. It is worth mentioning that there were several cases of "drug reactions" among those on the placebo.

Consider further a syndrome which has varied etiology, sometimes psychogenic, sometimes somatogenic, often with both factors to be considered. Crunden and Davis[4] gave a carbohydrate solution to 123 pregnant women for the relief of nausea and vomiting, and a sweetened placebo to a control group of 122. They reported their results as "marked improvement," . . . "some improvement," . . . "little value," . . . and "made worse." While the agent was statistically shown to be of superior value, about 15 per cent reported "some improvement" from the placebo and 8 per cent reported they were "made worse" by it.

In looking again at the table above, we see that the second group of drugs are the *"General Medications."* We all know that the patient "feels better" soon after he receives rapidly acting medications, but the gradual elevation of morale on recovery from a chronic illness is less well known. Yet every cardiologist has noted a gradual improvement in well-being which has taken several months to reach its peak after digitalization of a patient with heart failure.

Note group 3 in the tabulation on the previous page. They are essentially metabolic agents, and we list them apart from "general medications" to remind us that the brain needs the essential metabolites as well as the body. Here are a few of them:

Thyroid hormone

Deficiency causes sluggishness.
Excess causes emotional instability.

Adrenal Cortex Hormones

Cortisone sometimes causes psychoses.
Cushing's syndrome sometimes has marked lability of mood.

Adrenal Medullary Hormones

Epinephrine causes symptoms of anxiety and tension.

Ovarian Hormones

Estradiol and synthetic compounds, such as stilbestrol, relieve menopausal syndrome.

Pancreatic Hormone

Overdoses of insulin, either injected or from an islet cell tumor, cause trembling, faintness or syncope due to lowering of the blood sugar.

Thiamine Chloride

Deficiency causes "neurasthenia" and polyneuritis.

2. Simon, E. P. and Wright, I. S.: Effect of Heparin on Intermittent Claudication. Journal of the American Medical Association, 153:98 (September 1953).

3. Wolf, S. and Pinsky, R. H.: Placebo Administration and Toxic Reactions. Journal of the American Medical Association, 155:339 (May 1954).

4. Crunden, A. B. and Davis, W. A.: Phosphorated Carbohydrate Solution in Vomiting of Pregnancy. American Journal of Obstetrics and Gynecology, 65:311 (Feb. 1953).

Nicotinic Acid

Deficiency causes dementia, fatigue, insomnia.

Pyridoxine

Deficiency causes convulsions.

We all know—or should know—the importance of these metabolic agents. Patients should have received them, when appropriate, before having been sent to the psychiatrist. No one who has seen the return of mental alertness to a patient with hypothyroidism given thyroid, or recovery from the dementia of pellagra following the administration of nicotinic acid can fail to recognize the importance of the hormones and B vitamins for normal mental processes.

This brings us to the fourth group listed in the table: drugs which have a demonstrable effect on the brain.

Last year, the journal *Modern Drugs* listed over 300 new drugs, forms or combinations. Of these, 50 were listed under categories such as analgesics, anti-epileptics, anti-depressants, muscle relaxants or sedatives. We need not spend time cataloguing them. But the discriminating use of them is a fundamental part of the professional work of psychiatrists. Four subjects, however, seem worthy of special attention.

First, the use of isoniazid for multiple sclerosis. Though results are only preliminary, this disease is so common, so protracted in its course, and so little is available for its therapy that any advance in the field of multiple sclerosis is significant. Kurtzke and Berlin[5] noted that a chronically ill patient who was given isoniazid for another purpose than multiple sclerosis began to speak more distinctly.[5] They therefore gave isoniazid (300 milligrams daily in divided doses) to 30 patients, and compared the course of the disease in 175 other cases of multiple sclerosis which were or had been in the same hospital.* In order to make this comparison, they devised a chart of "categories of involvement in multiple sclerosis," with 10 categories. They found that 90 per cent of the treated patients showed significant improvement, while only 31 per cent of the comparison group improved. In the 17 patients whom they could follow for 6 to 18 months on a maintenance dose of 200 milligrams per day, this improvement was maintained.

Another group in Vienna found similar improvement in multiple sclerosis from isoniazid. They have not yet reported their results. This important subject is now being investigated on a larger scale by the method of double blind controls. We await the final answer.

Second, mention should be made of the special problem of parkinsonism. The effectiveness of certain preparations of the atropine series of alkaloids has been improved by combinations with one or more of the antihistamines. Yet the latter substances are not too dissimilar to the atropine group. This entire field is still an empirical one. Investigation leading to production of an animal analog of parkinsonism might provide an avenue to search for more specific drug therapy. This matter has an increasing urgency as gerontology becomes a larger part of our practice. For the present, the physician can only try the various agents and see their result on the patient. All the drugs have shown unpleasant side effects in some cases, or in large doses. The physician must start with small doses and gradually increase them until he obtains maximum benefit with minimal toxicity. A useful combination is Artane® with the antihistamine Thephorin®.

How about chlorpromazine and reserpine? These two agents, though distinctly different in structure, timing of action and several effects, both have the ability to depress some activities of the brain without markedly affecting others. Both reduce psychomotor activity without clouding consciousness (that is, tranquilize rather than hypnotize, to use dictionary terms) and are therefore useful in the treatment of mental disease. Both are likely to cause drowsiness, a parkinsonism-like syndrome, or further depress patients who are already de-

5. Kurtzke, J. F. and Berlin, L.: Effects of Isoniazid on Multiple Sclerosis. American Review of Tuberculosis, 70:577 (Oct. 1954).

*Veterans Administration Hospital, Bronx, N. Y.

pressed. The indications for their use, so far as seem indicated at present. are listed in the table, along with some of the undesirable effects.

From this preliminary summary we get the impression that they are acting on the central nervous system to produce similar effects but through different mechanisms. Just what these mechanisms are is not yet clear, but are probably complex since patients treated with reserpine may go through three stages—sedative, excitatory, and tranquilizing. Reserpine affects the metabolism of serotonin in some way. Reserpine has value in the treatment of hypertension, and chlorpromazine in the treatment of all sorts of conditions which produce nausea, vomiting or hiccups. For psychiatry and neurology, both agents have been found valuable in a wide variety of conditions, particularly those in which they calm the pa-

SOME EFFECTS OF TRANQUILIZING AGENTS

	Reserpine	*Chlorpromazine*
Blood pressure	Hypotensive, prolonged; valuable for the treatment of hypertension	Hypotensive, but brief and sometimes alarmingly severe (R: norepinephrine, *not* epinephrine)
Heart rate	Slowed	Speeded, usually
Temperature	Hypothermia	Hypothermia which may be useful in anesthesia: Fever, rarely and temporarily
Gastro-intestinal activity	Usually increased, even to diarrhea	Sometimes decreased to cause constipation
Nausea and vomiting	May cause them	Inhibits the vomiting center; it is best drug yet found to control nausea, but rarely may cause it
Hiccups	Questionable	Valuable for treatment
Appetite	Improved in some	Improved in some
Eye Signs	Miosis, common	Miosis, occasionally; mydriasis, rarely
Emotional states of anxiety, tension, agitation, mania, irritability, quarrelsomeness	Valuable for treatment	Valuable for treatment
Post-alcoholic excitement	Questionable	Helps
Alcoholic depression	Questionable	Makes worse
Emotional states of depression	Usually makes worse	Usually makes worse
Schizophrenia	Valuable for treatment in some cases	Valuable for treatment in some cases
Pain	Diminishes sensitivity by its calming effect	Potentiates narcotics; diminishes sensitivity and so diminishes need for analgesics
Potentiation of barbiturates	Reported not to potentiate	Potentiates effects
Other uses	May be helpful in narcotic withdrawal. bedwetting of children	Bedwetting
Unpleasant Effects		
Dry mouth	Common	Common
Stuffy nose	Common	Common
Jaundice	Uncommon	Rare, but may be severe, of "obstructive type"
Leukopenia	Not known	Rare
Fatigue	In large doses	In large doses
Parkinson-like syndrome	Common, reversible	Common, reversible
Allergies		Urticarial, some photosensitivity

tient. Particularly significant are the reports of improvement in hospitalized psychoses, including electroshock-resistant chronic schizophrenics after prolonged treatment. Despite the many unpleasant side effects of the drugs, they must be considered of great value.

We must take account of serotonin, which is a metabolite derived by enzyme actions in many tissues from the vitally important amino acid, tryptophane. Although the name, serotonin, was applied only in 1948 by Rapport, Green and Page,[6] the substance is known to be the same as observed by many authors in the last fifty years. A recent summary was published by Erspamer.[7] It begins to appear that serotonin belongs in the group of compounds with epinephrine, norepinephrine and acetylcholine. These are chemical intermediates in transmission of impulses within the nervous system.

Loss from the body daily appears to be only a few milligrams, although the metabolic details are very sketchily known. Since administration of serotonin by usual therapeutic routes fails to elicit those tranquilizing effects which have been produced by direct injection into the brain, it is probable that serotonin is not to be considered a therapeutic agent. But, the formation and release of serotonin in the tissues of the central nervous system may be a significant part of the mechanism which determines tranquility or excitement. Thus, for example, lysergic acid diethylamide, which can cause a schizophrenic syndrome, blocks the tranquilizing effects of serotonin. Reserpine, which tends to reduce schizophrenia, causes excretion of increased amounts of the end-product of serotonin metabolism. Since this occurs only at the start of reserpine therapy, it may be connected with the observation, already mentioned, that at first reserpine is sedative, then excitatory, and finally tranquilizing.

The ability to depress some activities of the brain without markedly affecting others is most encouraging. We are on the threshold of being able to "pin-point" our therapy, both in anatomic and physiologic senses. Yet, we are still groping in very dim light, so far as understanding how these most interesting newer compounds work. We hope to find more specific drugs in this field. One great handicap is our inability to recognize significant new substances for treatment of mental disorders before we enter direct clinical studies. The preliminary laboratory screening which led to selection of these agents (which are so active in treating mental states) had no direct connection with the uses subsequently discovered. It is important to remind clinical therapists of the urgency of observing as many of the consequences as possible with every unfamiliar drug. In this way, we detect not only the undesirable or side reactions, but also the unexpected new therapeutic opportunities.

The need for stimulating ("analeptic") drugs is at least as urgent as that for sedatives. The reciprocal relationship of these two groups of drugs and of the overactivity of one part of the mind, or underactivity of another, could lead us to an endless circle of words. The series of amines, beginning fundamentally with epinephrine, is too well known to be elaborated here. One of the problems in selecting a compound which will stimulate to greater mental activity is to avoid too intense or too rapid effects. Yet in the laboratory stages of the search for these substances, marked and prompt effects are almost indispensable. We have yet to achieve advances in this field analogous to the findings of reserpine and chlorpromazine in sedation. Meanwhile, it becomes necessary in therapy to use small doses of analeptic drugs and to wait for improvement to show in days or weeks, rather than minutes.

Roche Park

6. Rapport, M. M., Green, A. A. and Page, I. H.: Serum Vasoconstrictor Isolation and Characterization. Journal of Biological Chemistry, 176:1243 (July 1948).

7. Erspamer, V.: Pharmacology of Indolealkylamines. Pharmacologic Review, 6:425 (December 1954).

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Avulsion of Flexor Digitorum Sublimus

Rupture of the flexor digitorum sublimus tendon is rare, particularly when the avulsion occurs at the musculotendineus junction. It is even more rare to find this due to direct violence. Such a rarity is here reported.

In this country surprisingly little attention is paid to muscle and tendon ruptures. We have reviewed Index Medicus as well as standard texts and find that most of the contributions on the subject have come from foreign—particularly German—sources. And most of the cases refer to the commonest injuries of this organ system: rupture of the Achilles tendon, extensor quadriceps, biceps, triceps, rectus abdominis, trapezius, both pectorales, and adductors of the thigh.

Avulsion of the flexor digitorum sublimus at the musculotendineus junction is rarely reported. Edwards[1] did cite a case but the mechanism there was quite different. In his case the musculotendineus avulsion of the flexor was due to an explosion. He also reported one where the fingers were caught in a door. Our case, detailed below, is an avulsion of the musculotendineus juncture of the flexor digitorum sublimus due to direct violence. So far as we know this is unique. The mechanism is certainly obscure. The results were excellent.

While riding his bicycle, a 14-year old boy was involved in a collision with an automobile. He felt his right hand "jerk back." He is vague about the details but a piece of his flesh was found adherent to the door of the car. Otherwise his past medical and surgical history are negative. Except for the hand, physical examination showed nothing abnormal.

In the interdigital space (between thumb and index finger) there was a 2-inch jagged laceration. From this wound emerged the flexor tendon of the third finger. The tendon was about 12 inches long. A portion of the muscle belly was attached to the tendon. At a distance equal in length to the avulsed tendon on the volar surface of the forearm, there was (by palpation) a small depression. Here, exquisite point tenderness was elicited. "Point tenderness phenomenon" attending muscle injuries was tested in this case. The surrounding areas were carefully palpated and no pain was demonstrated. The sign was most exact and positive. Finger motion was present, but there was some inability to flex the longest finger. Extension caused a great deal of pain. The diagnosis was avulsion at the musculotendineus junction of the flexor tendon of the third finger of the right hand.

The tendon (with its several fibres of muscle mass) was wrapped in a gauze saturated with crystalline penicillin solution. Tetanus antitoxin was given and routine surgical care of a wound executed.

Necessary preparations were made in the operating room. An incision was made transversely on the volar aspect of the wrist about ¼ of an inch in length. A large hemostat was inserted into this surgical wound and caused to emerge out of the traumatic wound of the hand. The tendon was grasped carefully at its end and threaded back to the incision made in the wrist. Above in the longitudinal axis of the forearm another incision was made over the point of maximum tenderness. This corresponded to the termination of the tendon's length with the third finger kept straight. This incision encountered a hematoma which bulged into the incision. It was evacuated. Another hemostat was snaked through the first incision. Again

*This work is from the surgical staff of the Martland Medical Center. The authors are respectively surgical resident, associate member of surgical staff and attending surgeon at that hospital.

the tendon was picked up (threaded) and caused to rest on the muscle belly from which it had ruptured. It was sutured with chromic O catgut. The fascia were closed with chromic OO catgut and skin with interrupted silk sutures.

The hand wound was debrided and a rubber dam drain inserted. The wound was closed with silk interrupted sutures placed loosely. Following suture the hand was put in thirty degrees of flexion by use of a moulded plaster splint and made to assume the "Traffic Cop" position for twelve hours.

No motion of the hand was allowed for 3 weeks. The splint was removed to facilitate removal of skin sutures and drain after 7 days. The wound was clean and healed at this stage. Splintage was resumed for 2 more weeks. After a total of 21 days, the splint was removed completely and active exercises were instituted. Results were good. No adhesions between the tendon and skin wounds noted. Flexion of finger against resistance was good.

Immobilization: The after-care of tendon injuries has been the subject of contention for many years. Experience in our hospital, through differences of opinion (and at times from mistakes in adherence to instructions) has revealed that early activity in most cases led to poor results; adhesions and stiff fingers. In some cases it did lead to fair to good results. However, the preponderance of good results seem to favor late movement and immobilization for long periods. Location and nature of the injury are the most important factors. Poor results ensue, in general, with lesions of the flexor tendons near the distal one inch of the palm and proximal phalanx of the finger.

We here quote a paragraph from the experimental work of Mason and Allen [2] who have devoted a lifetime to this study. "Functional activity prior to the fifteenth day does not increase but weakens the healing tendon, provokes considerable tissue reaction, and causes the tendon to attach itself firmly to surrounding tissues. From the fifteenth day to the twenty-first day both mobilized and immobilized tendons increase in strength. Beyond the twenty-first day immobilized tendons do not increase in strength. Therefore, in conclusion and to dispel an old belief, *do not remove splint for three weeks,* provide flexion of the wrist in the splint, and in four weeks increase motion and use no support."

Bloodless Operative Field: Further review has pointed out that very little harm has followed prolonged use of the tourniquet, even for two to three hours. This modality, I believe, ensures good vision and is indispensable for constructive work.

Exercises: The rubber ball for exercise is outmoded. It does not give good results. The patient must flex *all* joints not only those at the metacarpal-phalangeal joints. He must hold the midjoint stiff and flex the distal joint and then hold the proximal joint stiff and flex the midjoint.

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Role of Histamine in Medical Practice*

The physiologic actions of histamine are simply set forth, and the usefulness of histamine in Meniere's disease, urticaria, certain allergies and special kinds of headaches, is spelled out. Dr. Alford also presents clearly the routes and modes of administration.

Histamine was discovered over forty years ago, and is the most widely distributed substance in living tissues. Its actions are specific and have a dramatic variety of effects on animal and human organisms. It was first identified in ergot by Barger and Dale,[1] in 1910, although it had been isolated previously by Yoshimura[6] from soy beans. In 1927 histamine was found to be a constituent of normal tissue in a "bound" form.[3] It is a decarboxylation product of the amino-acid histidine, and has a powerful pharmacodynamic activity. Histamine has been detected in every living tissue, with the highest concentration in the lung. An amount which would be toxic if liberated, is present in a "bound" and inactive form in the tissues of all animals.

Circulating blood contains 1.8 micrograms of histamine per hundred cubic centimeters. About 70 per cent of this is bound in an inactive form to the white blood cells. Histamine can be readily formed in the laboratory by the action of bacteria from the colon upon the amino-acid histidine.

Perhaps no other drug has the wide variety of actions possessed by histamine. There is hardly a tissue which will not respond in some way to this remarkable agent. The varied actions of histamine together with its wide distribution in the animal organism have provided the basis for many theories about the physiologic actions of this substance. The three chief physiologic actions of histamine are of both practical and clinical interest. Histamine produces a (1) contraction of smooth muscle. It is also (2) a powerful dilator of arterioles and capillaries. A third action (3) is an increase in the permeability of capillaries. This causes a loss of plasma protein and fluid through the capillary wall into the extracellular spaces, which results in edema. These three actions are reflected in the bronchial muscle contraction of asthma, the erythema of allergic skin reactions, and the edema of wheals which is one of the criteria of allergy skin testing.

Clinical symptoms from an injection of histamine are: flushing of the face, faintness, headache, sneezing, dizziness, and rapid pulse. These effects may persist for a period of several minutes to one of several hours. These symptoms are more alarming than dangerous. They do not occur unless the patient is given an amount of histamine beyond his tolerance. Thousands of injections have been given with no adverse reactions. Treatment with histamine has no more risk than any other hyposensitizing procedure.

Epinephrine is the specific physiologic antagonist to this drug. It will counteract the symptoms at once if administered in sufficient

*Read April 19, 1955, Annual Meeting, The Medical Society of New Jersey.

amount. Histamine is rapidly absorbed when administered hypodermically and is usually inactive when taken by mouth. A chemical process, possibly deaminization with subsequent oxidation, is supposed to account for the rapid detoxification of parenterally injected histamine. The lungs in particular capture histamine and also contribute largely to its removal. The release of histamine under various conditions can be demonstrated. The process of blood coagulation is associated with the liberation of the amine. The concentration of histamine in the venous blood of skeletal muscles increases during exercises proportionally to its activity. Heart muscle liberates histamine continuously. Conditions which accompany a deficient circulation tend to the liberation of histamine. The liberated histamine is considered one of the factors concerned in the readjustment of balance between the metabolic requirements of the tissues and their blood supply.

THERE is general agreement that histamine is a part of the allergic mechanism. The histamine in the tissues of a sensitized animal, is released into the blood and lymph as a consequence of the antigen-antibody reaction initiated by the re-injected antigen. There was a definite increase of histamine content in a series of patients with bronchial asthma during the development of symptoms as compared with levels found between attacks. In contrast with normal individuals, the histamine level in allergic patients shows enormous fluctuations. This level is markedly unstable in contrast to the striking stability of blood histamine in normal individuals.

The content of "unbound" histamine in patients with dermographism usually increases after application of a stimulus. Then within twenty or thirty minutes, after the stimulus, there frequently is a definite drop in histamine below the normal level. The findings suggest that blood histamine of allergic individuals is considerably more labile than that of the normal, and also that the liberation of histamine frequently follows the onset of allergic symptoms. In certain hypersensitive individuals, an increased liberation of histamine by physical agents seems to have been well established. Histamine may be implicated in the production of headache. It is a powerful dilator of arterioles and capillaries of the brain and meninges. Within a few seconds after the intravenous injection of 0.1 milligrams of histamine phosphate (in normal subjects) the systemic blood pressure falls and the cerebrospinal fluid pressure rises. While these changes subside and the blood pressure rises to normal, headache develops. The blood vessels chiefly responsive to histamine are the cerebral arteries, particularly the larger ones at the base of the brain. The extracranial and dural arteries play a minor role in contributing to this form of headache. Histamine headache depends primarily on an alteration in the caliber and tension of the blood vessels. Other investigators have reported that urticarial wheals contain a high concentration of histamine. Thus it has been demonstrated that the physiologic actions of histamine on smooth muscle and in its relation to edema have a bearing on clinical symptoms.

Repeated injections of graduated increasing doses of histamine raise the tolerance of animals to histamine. Treatment of allergic conditions by hyposensitization raises the threshold of the amount of allergen or antigen required to cause a release of histamine. The rationale of hyposensitization with histamine is not fully understood. However, the clinical results are satisfactory as reported by numerous workers. The diminished responsiveness of tissues to histamine (as a result of injections of histamine) is the basis for hyposensitization treatment.

Histamine is used in the treatment of a wide variety of clinical conditions. The literature covering these clinical uses of histamine is too extensive to review at this time. We are interested here in the use of histamine in conditions which are closely correlated on a physiologic and clinical basis.

HISTAMINE HEADACHE

SPECIFICALLY let us consider the use of histamine in histaminic headache, Meniere's dis-

ease, physical allergy and urticaria. Histaminic headache is a specific unilateral syndrome. The pain is sudden, constant, highly intense, burning and boring. In particular, it involves the regions of the eye, temple, neck, and face. It may extend into the shoulder on the involved side. Attacks often begin after middle age. Symptoms may last less than one hour, and may terminate suddenly. The pain often awakens the patient at night, and may be so severe that he jumps out of bed before fully awake. On the side affected, there may be unilateral profuse watering of the conjunctiva, rhinorrhea, nasal obstruction, increased perspiration and vasodilation in the skin. Swelling of the temporal vessels may be noted. So severe and frequent are the attacks of pain (often occurring every two hours, day and night, for a period of months) that some patients consider suicide. During and after attacks, marked tenderness is frequently found when pressure is applied over the branches of the external carotid artery. This pain is not confined to the distribution of any cranial nerve but conforms to the ramifications of the external carotid artery.

HISTAMINIC headache, according to Horton, may be distinguished from trigeminal neuralgia because trigger zones are invariably absent in the former and the pain does not follow the distribution of the fifth nerve. It is different from migraine because nausea, vomiting, and scotomata are absent in histaminic headache, and the attack usually lasts less than an hour. Heredity plays no role in histaminic headache.

Subcutaneous injection of 0.35 milligrams of histamine base will precipitate head pain in the average individual. In carrying out provocative tests, one must differentiate between the immediate generalized headache, which so frequently results from the subcutaneous injection of histamine base and the unilateral histaminic cephalalgia, which may develop thirty to fifty minutes later. The patient is unable to distinguish between induced and spontaneous attacks; the two are identical.

In the treatment of an acute attack, intravenous administration of histamine is the method of choice.[4] Make a solution of histamine base using 1 milligram to 250 cubic centimeters of isotonic salt solution, and give by drip method over 90 minutes. It may be given until relief is secured. As much as 15 milligrams of histamine base have been given over several weeks, to a single patient. If at any time the patient notices slight flushing of the face, the rate of flow should be reduced. When this phase of treatment is completed, histamine should be given subcutaneously. Make a solution of histamine base with 1 milligram to 10 cubic centimeters of isotonic salt solution. The initial dose is 1/10 of a cubic centimeter. It may be increased two or three times a week by that amount.

After the patient has become free of attacks, the second phase is to prevent future episodes. This is best accomplished by a proper maintenance dose. Fit the schedule to each patient.

MENIERE'S DISEASE

IN 1861 Dr. Prosper Meniere described a clinical disorder in the following fashion. "There are symptoms of vertigo, nausea, and the syncopal state which is accompanied by ear noises, and deafness. This is dependent on an alteration in certain portions of the labyrinth."

The causes of this syndrome still remain obscure. However, studies suggest that vascular changes occur which result in an increase in endolymph volume and pressure. This local extracellular edema affects the cochlea and results in the triad associated with Meniere's disease: deafness, tinnitus, and vertigo. Deafness is usually demonstrable in the tone scale and fluctuates in degree. The ear noises described by Meniere may be one of the most disturbing symptoms. The tinnitus is variously characterized as a penetrating hum, or roar. In most early cases, involvement is unilateral. The deafness is accompanied by decreased bone conduction. Sounds are often heard differently in each ear and a hypersensitivity to loud sounds may be present.

The vertigo, although referred to as the cardinal symptom of Meniere's disease, may

appear months or years after the onset of deafness. In some cases of endolymphatic hydrops, vertigo is absent. Vertigo is of a peripheral labyrinthine type. The attacks are often precipitous and may occur without warning. The pattern in regard to severity, frequency or duration is inconstant. Nausea, vomiting and falling may accompany the vertigo. The explosive nature of the episodes places a severe mental strain upon the patient. Remissions between attacks of vertigo occur with and without therapy but the symptoms of deafness and tinnitus often persist. The method of treatment is the same as that with histaminic headache.

URTICARIA

HISTAMINE is also indicated in the treatment of urticaria. Urticarial wheals contain an increased amount of histamine. Treatment is of particular benefit in the cases of physical allergy,[2] in which urticaria is a result of exposure to low temperatures. By the injection of small amounts of histamine in graduated doses, the urticarial response may be diminished.

Histamine is of little value in the treatment of hay fever or asthma.[3] In these conditions a search for the offending agents should be made and specific hyposensitization carried out.

Histamine as a diagnostic skin test should be condemned. Intradermal injection of histamine will produce erythema and a wheal in any normal individual and this is not an indication of an allergic state. As a diagnostic aid in the determination of gastric secretion, it is generally accepted and used.

SUMMARY

Histamine has three important physiologic actions:

(1) The contraction of smooth muscle.
(2) The dilatation of arterioles and capillaries.
(3) The increase in permeability of capillaries.

Histamine is available commercially as:

(1) Histamine Phosphate Tablets
1 tablet equals 1 mg. histamine base.
(2) Histamine Acid Phosphate Tablets
One ampule equals 1 mg. histamine base.

Histamine may be administered in the following manner:

Subcutaneously

(1) Make a solution of histamine base 1 milligram to 10 cubic centimeters of isotonic salt solution.
(2) Give 1/10 of a cubic centimeter as initial dose.
(3) Increase dosage by 1/10 of a cubic centimeter twice weekly.

Intravenously

(1) Make a solution of histamine base 1 milligram to 250 cubic centimeters of isotonic salt solution.
(2) Inject slowly over a period of 90 minutes.
(3) Give daily until relief. As much as 15 milligrams have been given in divided doses.

With this schedule, no untoward symptoms should be produced. Epinephrine is the specific physiologic antagonist.

Histamine is indicated in:

(1) Histaminic headache.
(2) Meniere's disease.
(3) Physical allergy.

Histamine is of little or no value in the treatment of asthma, hay fever, or other allergic states. It is of no value as a diagnostic skin test.

Histamine is a widely distributed constituent of human tissues and a substance of many actions. Its varied actions have provided bases for innumerable theories of physiologic function. The relationship between its pharmacologic action and its physiologic role in the human body remains obscure. There is a growing conviction that its participation in normal and disturbed physiologic processes may be far more significant than is now appreciated. Its value as a therapeutic agent appears to be well established. The statement that histamine is a drug of considerable academic interest but little therapeutic importance is undergoing revision. This discussion has been an attempt to correlate the known physiologic actions of histamine with its work-a-day clinical use. Many

patients can be helped through the proper administration of histamine. The knowledge that will come from the further study, observation, and experience of each one of us may reveal in the future new indications for the use of this remarkable substance.

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Is The "Ulcer Personality" a Myth?

It is common to think of this person or that as an "ulcer" type—the reference being to temperamental, not physical characteristics. Writing in the July 1955 *Archives of Internal Medicine*, Dr. Harold P. Roth challenges the validity of this concept. He found that a number of different personalities were described as typical in various studies on the topic. "There was no whole personality or feature of personality that was agreed upon by as many as a third of the investigators," he said.

Personality traits most frequently mentioned were drive, conscientiousness, and anxiety. "Although other traits were described, the statements about most of them were contradictory," he said.

Some authors suggested that ulcer patients had a specific type of conflict. But they did not always agree on the nature of the conflict nor whether the conflict was associated with a specific personality type.

The conflict most frequently reported was between feelings of passivity and feelings of activity and independence. Because this same conflict is seen in persons without ulcers, "we must know how often this conflict can be found in the general population before we can decide how significant is the fact that it is found in ulcer patients," Dr. Roth said.

"We cannot say whether the fact that a number of investigators described the same personality features is significant, for this may be due to a defect in their technic."

In half of the reports, no method of study was outlined. Some were based on interviews, some on psychological testing, and some on analysis.

No distinction was made between patients with gastric ulcer and those with duodenal ulcer nor between male and female patients in many of the studies. Yet investigators who studied these groups separately found there were differences in personality.

"Conclusions about the ulcer personality in the general population have been drawn from studies of samples that were not representative," Dr. Roth said.

"Usually the author did not report how often he found a given characteristic, such as ambition, in his patients . . . Generally he reported his conclusions, not his data," he said.

"An entirely satisfactory" method for evaluating personality has not been developed, nor has a method for comparing ulcer patients with ulcer-free persons, Dr. Roth said.

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Dissecting Aneurysm of the Aorta Associated With Nonspecifc Pericarditis*

Though the authors say it is "relatively common," a dissecting aneurysm of the aorta is not, as cardiovascular lesions go, a really common disorder. To have it co-exist with a pericarditis and an aortitis must be exquisitely rare. Here is a case, possibly unique in modern medical annals.

Formerly a pathologic rarity, dissecting aneurysm of the aorta is now relatively common. The clinical diagnosis is, however, often missed, being mistaken for coronary thrombosis, acute cholecystitis, and even Yoo-Yoo disease†. The diagnosis of dissecting aneurysm of the aorta can no longer be considered only an exercise in clinical acumen. Vascular surgery now offers the hope of cure.

A typical clinical picture of a patient with dissecting aneurysm follows: He is middle-aged and hypertensive. Coronary thrombosis is the initial diagnosis. The onset of pain, however, is described as tearing rather than squeezing. The radiation is more widespread. His ruddy facial bloom remains and his known blood-pressure (what hypertensive is not an authority on this?) varies but little. But there is a marked difference between the two arms. The pulsations in the femoral arterial vessels or distal are feeble or absent. Hemoglobin is lowered. The roentgen report of the chest notes a widening of the thoracic aorta. The electrocardiogram does not confirm a diagnosis of coronary thrombosis.

When another cardiovascular disease is associated with dissecting aneurysm then the diagnostic difficulties are compounded. Such a case is reported below:

A white male of 65 was admitted to the medical ward of West Jersey Hospital with a diagnosis of coronary thrombosis. That morning he had been working at his usual occupation of grave-digger. As he was resting on his shovel he noted a severe tearing pain traveling across his chest from the left to the right side. He lost consciousness. On regaining it he found himself in a hospital bed, his pain gone and without any complaints. He then had a blood-pressure of 160 systolic, 100 diastolic in the left arm. Heart rate was 120. Remainder of the examination was noted as normal.

The significant laboratory data on admission were: a polymorphonuclear leukocytosis, an increased sedimentation rate, and a blood urea nitrogen of 40 mg. per cent.

The conclusion of the electrocardiogram (2 days after admission) read: "This is a diffuse global type of infarct or acute pericarditis" and (4 days later): "probably pericarditis."

On the latter date the patient developed auricular fibrillation. There was no response to procaine amide[1] and quinidine caused only a temporary slowing of the cardiac rate.

Next day the patient was alert; there had been no significant change in his blood pressure since admission. The jugular veins were not distended. The cardiac rhythm was auricular fibrillation. A distinct pericardial friction rub was heard. Femoral

*From the medical service of the West Jersey Hospital, Harold K. Eynon, chief.

†Bierman, H. R. New England Journal of Medicine, 252:274 (February 17) 1955. Also, see "Standard Nomenclature of Diseases and Operations" Edited by R. J. Plunkett and A. C. Hayden. Ed. 4. Philadelphia: Blakiston, 1952. P. xii.

1. Used under the Squibb trade-named designation "Pronestyl."

and dorsalis pedis arterial pulsations were barely palpable. A diagnosis of dissecting aneurysm of the aorta was made.

It was difficult to explain the pericarditis. Rarely, a dissecting aneurysm may dissect along one of the coronary vessels, producing a hematoma which in turn occludes the vessel by external pressure, thus producing an infarct and this in turn a reactive pericarditis. By this time the numerous electrocardiograms would have produced some evidence of myocardial infarction and since there was none, an explanation was beyond our ken.

A roentgenogram of the chest was reported at this time as showing a widened thoracic aorta and the diagnostic ground became more firm.

The patient continued in a subjectively asymptomatic state despite a refractory auricular fibrillation and a rising blood urea nitrogen. Sixteen days after admission he developed symptoms of cerebral anoxia, becoming irritable, hyperactive, and then delirious, requiring restraints. Two days later he developed ventricular tachycardia and died.

REPORT OF NECROPSY

THE pertinent findings of Drs. A. S. Couston and W. J. Gavilondo are summarized:

Heart and Vessels: The heart is of normal configuration but moderately increased in size, weighing 430 Grams. The epicardium is reddish gray and dull and has flakes of fibrin attached to it. Myocardium is dark reddish brown and firm. Endocardium is smooth. Valve cusps are thin and delicate and of normal configuration. The coronary arteries arise and course normally and show no evidence of sclerosis or occlusion.

The cardiac measurements are as follows: TV—14.0 cm., PV—9.0 cm., MV—9.0 cm., AV—7.5 cm., RVW—0.4 cm. and LVW—1.5 cm. About 25 millimeters from the root of the aorta there is a tear through the intima and media measuring 2.5 centimeters in length with the presence of blood between the adventitia and the media. There is a patient channel in the wall of the thoracic and abdominal aorta and reopening in the left iliac artery

MICROSCOPIC EXAMINATION

Aorta: The intimal aspect is essentially intact. The inner two-thirds of the media show a preservation of the fibrillar appearance. However, as the outer portion of this is reached, less and less cellularity is apparent. Beginning at the junction of the outer and middle thirds of the media, there is an area of necrosis through which is produced a widening and splitting of the wall. This area contains clot-like material. Some fibroblastic activity is seen on the outer aspect of this accessory channel and there is an infiltration of lymphocytes. This latter process extends out into the adventitia in which there is lymphocytic infiltration, sometimes perivascular in nature with considerable proliferation and thickening of the adventitia. This is accompanied by increased vascularity and the application of a thin layer of fibrinous debris on the adventitial surface. The inflammatory reaction is predominantly fibroblastic with a scattering of lymphocytes, rare plasma cells and monocytic cells also seen. The character of this reaction is entirely nonspecific.

Examination of the pericardium reveals similar changes. There is fibroblastic thickening, some collagenization, increased vascularity and an infiltration by lymphocytes with scattered other cells. There is slight mesothelial proliferation in some areas. On the visceral pericardium, the fibroblastic reaction has resulted in replacement of much of the epicardial fat. Here again the inflammatory reaction is nonspecific.

SUMMARY

THE very rare and apparently fortuitous association of aortitis, pericarditis, and dissecting aneurysm of the aorta is reported. The inflammatory reaction in the aorta may have produced the stress in the diseased media of the aorta which precipitated the dissection. Thus the accepted etiology of a degenerated media by itself initiating the process of dissection is not always the complete answer.

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The Common Cold*

Viewpoint of the Otolaryngologist

Antibiotics and antihistaminics have little value in the treatment of the uncomplicated cold, according to this presentation. A common sense treatment is suggested.

During the past two decades, better understanding of nasal physiology has changed the otolaryngologist's concept of the common cold. Because of bacteriologic, pathologic and physiologic study a clearer conception of some of the factors associated with the common cold has evolved. Even though the otolaryngologist can do little to prevent or eliminate the cold, patients can be relieved symptomatically and complications can be prevented by attention to adequate nasal ventilation and proper drainage.

The nasal mucosa is covered by a blanket of mucus which rests upon the ciliary bed. The effectiveness of the ciliary action is demonstrated by the fact that it only takes about twenty minutes for the mucous blanket to make a complete cycle from the anterior portion of the nose to the nasopharynx. During this passage, it collects bacteria and particles of dust and dirt and removes them from the nasal passages. The blanket of mucus is protective. When it is penetrated by the virus of the common cold, infection begins in the mucosa and the ciliary action is slowed. A virulent virus may penetrate the mucous blanket in the nasal passages. Drying of the nose, chilling and alterations in body metabolism may allow the ever-present bacteria to penetrate through the mucosa into the submucosa. This marks the beginning of the suppurative stage of the cold, and the time at which complications may start. During this stage, antibody formation and active resistance are pronounced.

Nasal medications are not innocuous. Some produce chemical irritation. The use of nose drops over prolonged periods of time should be discouraged. The ideal vasoconstrictor for use in the nasal congestion of a cold is non-irritating, does not inhibit ciliary action and approximates the pH of normal nasal secretion. Some drugs, notably naphazoline[1] have produced a chemical rhinitis from continued application. It is probably better to substitute a general prescription consisting of ephedrine sulfate 3/8 grain and phenobarbital 1/2 grain to be taken internally to relieve nasal congestion rather than to depend on the continuous use of nasal medications. Silver protein solutions[2] are too irritating to the membrane for even limited use.

Mild medication is preferred locally in the nasal passages. Any medication with an oily base is deleterious to the nasal cilia, and a physiologic saline base should be substituted. The oily solutions are especially prone to cause pulmonary complications in infants and young

*Read April 18, 1955 at the Annual Meeting of The Medical Society of New Jersey.

1. Tradenamed by Ciba as "Privine."

2. Such as the mild silver protein, tradenamed by Barnes as "Argyrol."

children from aspiration of oil with subsequent lipoid pneumonia. In addition to this drawback, the oily material inhibits ciliary activity, so that instead of eliminating secretion and bacteria by active ciliary movement, the secretion becomes stagnant and secondary infection more marked. Any medication which retards ciliary activity in the nose prolongs the infection and invites complications.

IN APPLYING nasal medications, a spray or vaporizer is more effective than drops. A finer droplet allows better access to the superior and posterior portions of the nose. In the office, vasoconstrictors applied to cotton pledgets and placed along the inferior turbinate give satisfactory nasal shrinkage and ventilation. If there is marked swelling and tightness about the middle meatus, a cotton-tipped probe saturated with a vasoconstricting agent can be inserted into this recess to re-establish patency in the region of the sinus ostia.

Mass nasal suction is condemned for any benefit is off-set by the pronounced secondary reaction in and around the sinus ostia. The nasal vasoconstricting agents also produce secondary reaction, but their benefits partly offset their ill-effects by allowing at least temporary sinus drainage, which aids in the prevention of complicating purulent sinusitis.

When acute sore throat develops with a cold, hot saline irrigations are probably as beneficial as any other method of treatment in providing symptomatic relief. Strong caustics, such as silver nitrate and iodine, should be avoided. While antiseptic mouth washes and gargles make the throat feel cleaner, they have little destroying effect upon the responsible bacterial flora.

Antihistamine therapy has been tried in the cold but this exerts little permanent benefit on either the duration or the outcome of the cold. When used early there may be a slight drying effect on the thin, serous discharge, but no appreciable lessening of symptoms or alleviation of the infectious stage follows.

It has been my experience that sulfonamide or antibiotic solutions alone or in combination with vasoconstrictors are alkaline, irritate the nasal and sinus mucosa, and may cause drug sensitivity in the individual. *I see no advantage in the local use of antibiotic therapy in the nose* and much to discourage this practice.

There is no rationale for the systemic administration of antibiotics in the common cold. The only possible benefit seems to arise from healing of secondary infection. The purulent secretion lasts only from three to five days so that the use of antibiotics should be restricted to that period. Although some benefit is probably derived, the disease itself is self-limited, and it would seem desirable to avoid antibiotic therapy altogether if the patient is not too ill.

No medication has yet been discovered that has an antiviral action but it may be that in the future we will see the development of a vaccine which will produce enough immunity in the individual to resist the viral agents of the common cold.

WHILE the conventional common cold is due to a filterable virus followed by secondary infection, an allergic type is also seen by the otolaryngologist. These patients complain of frequent head colds with profuse thin nasal drainage. In reality this is not a common cold but a manifestation of allergic rhinitis, although the patient commonly attributes it to a cold. Finally, there is a type which combines the infectious and allergic components.

In a patient with a common cold, the nasal mucous membrane is inflamed and swollen and is usually covered by a thin, colorless secretion which later becomes definitely purulent. Associated with this is a profuse postnasal discharge and injection and inflammation of the pharyngeal or laryngeal mucosa. In the early stages, general treatment by medical measures is more effective than any local treatment. It is not possible for the otolaryngologist to "dry up" the profuse secretion and cure the cold. The judicious use of nasal vasoconstrictors gives temporary relief and can be used along with salicylates, fluids and bed rest.

The most frequent complication of a cold is sinusitis. The maxillary sinus is the one most frequently involved. When sinusitis oc-

curs, systemic antibiotic treatment together with sinus irrigation and drainage is indicated. When the patient is treated during the course of a common cold rather than allowing the cold to run its course, acute purulent sinusitis can be prevented in many instances and more drastic treatment is not needed. I have no personal experience with vaccine therapy in the prevention of the cold, but it is my impression that the results are unpredictable.

Sinusitis from mechanical interference with drainage of the ostia which deflects the air currents and impedes ventilation may follow an acute cold. Chemical irritation from medication, caustic vapors, or ill-advised treatment predisposes to secondary obstructive sinusitis. Pain with a feeling of pressure in the involved sinus develops when negative pressure is established from blockage of the ostium.

As the common cold progresses and infection becomes a primary element, the marked nasal blockage is accompanied by purulent discharge and pain. As the disease continues the purulent discharge becomes profuse, thick and tenacious. When this occurs inflammatory swelling of the membrane occludes the ostia early and usually the pus can be traced to the ostium of the infected sinus. Bacterial cultures help in determining the responsible bacteria and in guiding treatment, for it is at this stage that antibiotic therapy given systemically is beneficial. In the very early stages, bacterial sinusitis resolves when treatment is directed toward the nose and the ostia are kept patent. Care must be taken not to damage the drainage mechanism. Nasal shrinkage with vasoconstricting agents placed about the sinus ostia establishes adequate drainage in the usual case.

In bacterial sinusitis supplemental penicillin therapy shortens the course of the infection, diminishes the number of serious complications, reduces the number of cases requiring surgery and when surgery is needed, permits the use of less formidable procedures. These drugs by combating the infecting organism in the early stages of the sinusitis and the latter stages of the cold, also eliminate the pathologic changes resulting from long-standing infection. Commonly the causative organism belongs to the Gram-positive group and is sensitive to penicillin. Better results are obtained when penicillin is given early, and staphylococci infections yield the best results.

A second common complication is otitis media especially in children. When this develops, systemic antibiotic therapy should be given early and if there is any indication of fluid or pus, the drum should be promptly incised.

Another complication is acute laryngitis when the infection spreads down the respiratory tract. Voice rest together with steam inhalations using menthol crystals or compound tincture of benzoin has proved beneficial.

The treatment of these complications or sequelae is more important than the treatment of the common cold itself. Most of the patients under the care of a general practitioner are referred to the otolaryngologist when complications develop.

In allergic rhinitis the chief complaint is constant nasal discharge which the patient usually describes as a continual cold. This is accompanied by nasal blockage, sneezing, coryza, lacrimation and itching about the eyes. In contrast to the typical pale and boggy appearance of an allergic membrane, the membrane may appear normal between attacks. During an attack of allergic activity it may be intensely inflamed resembling an acute infectious coryza. It is difficult at these times to distinguish the allergic from the infectious factor. Although a high proportion of eosinophiles is frequently found in nasal smears in allergic individuals, an absence of eosinophilia does not exclude allergy.

In allergic conditions, treatment is directed primarily toward the allergic diathesis. If allergic factors are present, the life and habits of the individual must be regulated accordingly. Active treatment consists of desensitizing when sensitivity to specific excitants is found and antihistamine drug therapy for temporary relief. Locally, shrinkage agents afford little benefit but some relief may follow electrocoagulation or sclerosis of persistent inferior turbinate swelling. Nasal polyps may form and sometimes

can be eliminated when the general allergic status is controlled. Generally they become organized and have to be removed surgically.

In patients who have both infection and allergy as the underlying cause, a local nasal abnormality may be present which, when corrected, helps the patient. It seems better to direct treatment toward the infection first, and after this has been eliminated, the allergy can be treated. In these cases, it is often necessary to employ the antibiotics systemically until the infection has subsided, then attack the local nasal abnormality and finally, try to uncover the responsible allergic agent, if one exists.

SUMMARY

WHILE the patient with a common cold frequently consults the otolaryngologist, medical management is paramount. The function of the otolaryngologist is (1) to determine whether the complaints are infectious or allergic in origin or a combination of both; (2) to direct treatment toward preventing complications and (3) to treat complications when they developed. In the uncomplicated cold, antihistaminic and antibiotic treatment have little value but can be used to advantage when complications indicating their use occur.

1719 Rittenhouse Square

The Future of Venesection

We usually associate venesection, or bloodletting, with medicine's dark ages, and wonder less at the victims who died "anyway" than at those who survived. Yet, the author of this entertaining paper† writes that "no form of treatment could have been used as extensively over so many centuries without having some basic value." Even today, it is recommended by standard texts for treating certain stages of a few disorders. Diseases in which "bleeding" may prove useful include erythremia, hemochromatosis, and—with simultaneous blood replacement—erythroblastosis and occasionally leukemia and hemophilia. In erythremia, however, radioactive phosphorus is now preferred to bloodletting. Venesection may also be employed as an emergency measure in plethoric patients until such modern aids as oxygen, digitalis, and diuretics can be given. Bloodletting will also reduce the blood pressure in arterial hypertension, but the modern hypotensive agents will probably render this use relatively infrequent. Thus, while venesection is still with us, it is probably on its way out—at least as a therapeutic measure—and the author suspects it may survive only for the emergency relief of excessive venous pressure.

The fact that venesection is of recognized value in a few conditions may help to explain the occasional "successes" which must have encouraged our predecessors. The dramatic nature of the treatment may also have had a psychotherapeutic effect on some patients.

The history of venesection, as reviewed in this fascinating account, is an amazing one. The custom goes back to ancient times and remained popular well into the nineteenth century. In addition to its therapeutic value, it was held by some to possess prophylactic virtues. Thus, the Jews acquired the practice of what they called "dietetic" bloodletting, performed regularly once each month up to the age of 60; after that it was done less frequently.

However dim the future of therapeutic bloodletting may seem, venesection will continue to be common. For how else do we acquire the vast amounts of blood required for transfusions? The author points out that "there is some evidence to show that the rate and quality of blood cells and plasma protein regeneration are improved by controlled bleeding." Should this hopeful rumor be confirmed, a little judicious propaganda might encourage the revival of an ancient custom. The happy result would be more blood donors and an augmented supply of blood needed for transfusion.

† Holman, D. V.: Bulletin of the New York Academy of Medicine, 31:661 (Sept.) 1955.

Fred B. Rogers, M.D.*

Trenton

Dr. John Browne --- Friend of Benjamin Franklin

Not the John Brown whose body lies a-mouldering in his grave, but the one who for many years was a friend of Benjamin Franklin's is the subject of this illumination of an obscure corner of American history.

Recent publication of the complete writings of Benjamin Franklin by Yale University has prompted closer evaluation of the life and works of this celebrated eighteenth-century American. Printer and publisher by profession, Franklin achieved world-wide fame as a statesman, scientist, educator and author. The straightforward style and practical value of his writings account for their continued popularity to this day. His personal charm and convivial spirit, moreover, add another facet to his many-sided nature, one which resulted in a friendship with Dr. John Browne, an almost-forgotten physician in colonial New Jersey. Their first meeting, described in Franklin's *Autobiography*, began an acquaintanceship which lasted for fourteen years—from 1723 until Browne's death in 1737. As a result of Franklin's sketch of the doctor's character and from a few facts still available to us, we can reconstruct something of this early physician and his surroundings in colonial America.

On a stone tablet in the wall of the north vestibule of Trenton's historic St. Michael's Episcopal Church, one can read the following inscription:

1737 — In Memory of Doctor John Browne who Departed Life May ye 11th. In the 70th yer of his age. Born in Northampton In Old England & Educated IN LONDON.

The Soul and Body which he Wore
To God he Freely did Restore
To Keep it as He did BEFORE.

Just below this epitaph with its odd mixture of capitals and lower case letters, there appears this legend: "This stone was removed from the family seat on the Banks of the Delaware by his grand-daughter, Lucy Jarvis, and placed here by his great-grand-daughter, Elizabeth Lawrence Highbee, 1825." To preserve this relic further, it was moved from the churchyard into the church itself in 1924. From its present location the inscription directs us to the past, recalling a scarcely-remembered friendship between two colorful figures in the early years of the eighteenth century.

In his autobiography, Benjamin Franklin, describing his journey to Philadelphia in October, 1723, at the age of seventeen, tells of meeting a Dr. Brown(e) at the latter's home near Burlington, New Jersey. After quarrelling with his brother, James, Franklin had secretly left Boston on an exhausting journey to New York and Philadelphia. He states that inclement weather and no food or sleep for thirty hours caused him much distress during his coastal voyage from New York to Perth Amboy. A fever developed, which he con-

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trolled by drinking large amounts of cold water. His enthusiasm was dissipated by the time he reached New Jersey. From Perth Amboy, Franklin tells us:

> I proceeded on my journey on foot, having fifty miles to Burlington, where I was told I should find boats that would carry me the rest of the way to Philadelphia.
>
> It rained very hard all the day, I was thoroughly soaked and by noon a good deal tired, so I stopped at a poor inn, where I stayed all night, beginning now to wish I had never left home. I made so miserable a figure, too, that I found by the questions asked me I was suspected to be some runaway servant, and in danger of being taken up on that suspicion. However, I proceeded the next day, and got in the evening to an inn within eight or ten miles of Burlington, kept by one Dr. Brown.
>
> He entered into conversation with me while I took some refreshment and, finding I had read a little, became very sociable and friendly. *Our acquaintance continu'd as long as he liv'd.* He had been, I imagine, an itinerant doctor, for there was no town in England, or any country in Europe of which he could not give a very particular account. He had some letters and was ingenious, but much of an unbeliever and wickedly undertook some years after to travestie the Bible in doggrel verse, as Cotton had done Virgil. By this means he set many of the facts in a very ridiculous light, and might have hurt weak minds if his work had been published: but it never was. At his house I lay that night and the next morning reached Burlington.

In a recent biography of Benjamin Franklin, Phillips Russell recounts the above anecdote in modern dress:

> His spirits touch bottom that night when at a poor inn he is questioned as if he were a runaway servant. He knows he looks the part. His rough, home-made working clothes are stuffed with his belongings. He has been without sleep. And he is very wet.
>
> When things reach their lowest point, there is nowhere for them to go but up. The next day he finds a better inn, kept by a Dr. Brown, a defeated and disillusioned man. But the old fire re-kindles when Brown discovers in this bedraggled youth an alert mind, a bookish taste, an original turn of speech, and a quirky humor. They discuss the state of letters, philosophy, politics, religion, men, women. They take stock of the universe, laughing as they look down upon its antics from a far height. They return to earth and tell each other earthy stories.
>
> The next day Benjamin finds the world recuperating. The conversation with the vagabond doctor has exercised the evil spirits from his mind. The droll smile returns to his rounded countenance.

Information regarding the personal and professional life of Dr. Browne, aside from the glimpse afforded in Franklin's *Autobiography*, is not readily available today as the physician's activities have been obscured by the passing of more than two centuries. From the facts available, however, we can develop a picture of the man and his surroundings.

New Jersey was one of the early territories settled in the New World and the first to organize a provincial society of medical men. But its records are sparsely sprinkled with accounts of the development of its medical profession. Some insight into the status of medicine and everyday life in colonial New Jersey may be obtained, however, by examining newspapers of this period. A voluminous collection of such material is available in *The New Jersey Archives*, an exhaustive and scholarly series of works published by the State of New Jersey under the auspices of the New Jersey Historical Society. These volumes were published in series form from before the turn of the last century until recent years. Several references to Dr. John Browne appear in these *Archives* for the years 1691 to 1737. They attest to his being a man of prominence and medical skill in colonial New Jersey.

By 1700, the population of New Jersey was between fifteen and twenty thousand. Burlington, Perth Amboy, Newark, Elizabeth, New Brunswick and a few other towns were somewhat settled; but the colony was essentially a rural area. A doctor, wherever present, was a significant person in his community. The colonial physician, whether well or poorly versed in the medical lore of that time, labored under the handicap of being isolated from the scientific world of his day. But what he lost thereby, he frequently gained in courage and resourcefulness. In this early period, an era rife with epidemic disease, citizens with some formal medical training, such as Dr. Browne, were valuable indeed.

From his gravestone we learn that John Browne was born in Northampton, England, in 1667. (That was the year in which Milton's *Paradise Lost* appeared in print.) Following education in London, we assume he travelled on the continent, perhaps making the grand

tour of medical centers in France, Italy and Holland. Franklin commented on his host's familiarity with towns in England and other countries of Europe. This is understandable as study at the medical schools at Montpellier, Padua or Leyden comprised a portion of the well-educated British physician's training in the seventeenth century. Such study, for example, formed part of the medical backgrounds of Thomas Sydenham, William Harvey and Sir Thomas Browne—three outstanding English medical men of this period.

We do not know where Dr. John Browne took his medical degree, nor the year, nor the exact reason for his emigration to America. From the parody he composed on the Bible, however, one may suspect that his irregular views on religion hastened his departure from Europe. The doctor-innkeeper's travesty on the Bible, composed in doggerel verse, was facetiously referred to as "his great work" in the out'ine for Franklin's *Autobiography*. We can only regret that none of Browne's unusual verse has survived, with the possible exception of the few sober lines of his epitaph. His doggerel verses might have contributed a unique item of early Americana.

THE name John Browne first appears in a New Jersey colonial document dated March 4, 1691. This document is a legal release from the provincial proprietor Daniel Coxe and his wife conveying the government of their territorial grant to the West Jersey Society composed of forty-eight landholders. Four years later, in March 1695, John Browne is listed as a member of the provincial House of Deputies meeting with Governor Andrew Hamilton at Perth Amboy. Browne's name is also connected to three legislative bills in that month, statutes pertaining to the support of the government, construction of a road to Burlington, and the state of Negroes in the province.

On June 1, 1700, John Browne's signature appears on a lengthy petition protesting disagreeable acts by the proprietors and asking for the appointment of a competent governor by the Crown. In colonial New Jersey the desire for independence was fostered by constant friction between the Council of Proprietors and the provincial citizens who questioned the authority of the proprietors or were restive under the exaction of yearly quit-rents by these dignitaries in England. The proprietors were so closely identified with the Royal government that as the people became accustomed to resist the former, they found it easy to dispute the right of a foreign King to control their affairs. John Browne is subsequently mentioned as receiving ten pounds pay as a "searjant at arms" in the colonial Assembly convened under Governor Robert Hunter in March, 1716.

From 1704 to 1719 the only American newspaper was published in Boston. After 1719, similar journals appeared in New York City and Philadelphia. In *The American Weekly Mercury* (New York) for August 25 to September 1, 1726, there appeared the fo'lowing notice:

> Run away on 29th of August last, from Docter John Browne in York Road, West Jersey, a servant Woman, named Sarah Parler or Sartin, supposed to be Inveigled or Conveyed away by one Richard Sartin, who served his Time at French Creek in Pennsylvania, at the Iron Works, who pretends that he is her Husband, but is not; she is a little, thin Person, having on a Calico gown strip'd with Blue, or a black and white one of Woole and Worstead, a new Bonet, and other tolerable good Cloaths. Whosoever takes up said Servant Woman and secures her to her said Master, shall have Forty Shillings as a Reward and all lawful charge, paid per me—John Brown.

This advertisement for the return of the doctor's runaway servant recalls the colonial paradox of Europeans seeking freedom in America by indenture to pay for their passage across the ocean. Others, of course, had been brought over against their will and sold for a term of years into a modified system of bondage. The curious clothing worn by the runaways and described in numerous similar contemporary newspaper notices indicates the formerly genteel condition of some of these colonists. Several newspaper items in Benjamin Franklin's *Pennsylvania Gazette*, advertising farmlands for sale, indicate moderate property holdings by Dr. Browne in the vicinity of Burlington. From February 16 to 23, 1730, his own residence was offered for sale in *The Pennsylvania Gazette*:

To be SOLD, The Seat or Plantation belonging to Dr. Browne, where he now lives, containing about 230 Acres of very good Land fit for either Wheat, Clover Pasture, or Meadow; well Timber'd scituate between the River Delaware and York Road, about nine Miles from Burlington, with two convenient Landings, one to the River, and the other up a Creek near the middle of the Land; upwards of Thirty Acres are clear'd, a very convenient House, Barn and Stables with other Outhouses, all in good Repair; and a very good Orchard: There are few Places which exceed it, both for Pleasure and Profit. Any Person that hath a mind to buy, may apply to the said Dr. Browne before the 30th Day of March next, or on the said Day it will be sold by Vendue to the highest Bidder, at Mr. Micajah How's, 9 Miles from Burlington, where said Dr. Browne formerly liv'd.

One can surmise that the doctor, then an elderly man, lived in retirement following the sale of his "plantation." This sale may have been prompted by illness or infirmity for the following notice appeared in *The Pennsylvania Gazette* for May 12 to 19, 1737:

We hear from Burlington County that on the 11 Inst. died there of a Stoppage in his Urine, Dr. John Browne, a Gentlemen of singular Skill in the Profession of Surgery, which he practiced in those Parts many Years with great Success, and was well esteemed by all that knew him.

This simple obituary may have been written by Benjamin Franklin, who was then editor of *The Pennsylvania Gazette*. Franklin had known the colorful and erudite doctor for fourteen years by that time, since their first meeting which Franklin never forgot. The disheartened young man's spirits were raised considerably by the wit and discernment of this pioneer physician of the Delaware Valley. Franklin's brief anecdote describing his encounter with Dr. Browne forms a small, but significant detail in the unsurpassed story of how a humble printer's apprentice came to Philadelphia and rose to be one of the world's great figures, and "the most complete representative of his century that any nation can point to."

ACKNOWLEDGMENT

The author wishes to acknowledge the assistance of the Rev. Warren L. Howell, Rector of St. Michael's Episcopal Church, Trenton, N. J.

Donnelly Memorial Hospitals

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"On the Shoulders of Giants"

In the *Authors' Clinic*, page 649 of the December, 1955, JOURNAL, we had a footnote indicating our inability to trace the source of the phrase "standing on the shoulders of giants". Dr. R. F. Maddren of Hackensack has furnished the missing source. He writes: "When a sycophant tried to flatter Isaac Newton by calling him greater than Descartes, Newton replied: 'If I *have* seen farther than Descartes it is because I have stood upon the shoulders of giants'."

Thank you, Doctor Maddren!

Trustees' Meeting

At its November 13 (1955) session, the Board of Trustees:

—Heard that the Commissioner of Banking and Insurance had disapproved of the proposal for supplemental MSP contracts for subscribers in higher income brackets.

—approved a request from the MSP Board endorsing a limitation of $7500 a year income, this to include the joint income of subscriber and spouse. The $5000 ceiling on single person contracts is not affected.

—recommended to the MSP Trustees a new subscription contract which would implement the action of our House of Delegates with respect to including the fields of radiology, anesthesiology and laboratory medicine in the scope of "medical services".

—agreed to co-sponsor the Annual Cancer Seminar in Atlantic City in November 1955.

—confirmed President Butler's replacement of Dr. Blaugrund, who could not serve, with Dr. Edward Duffy as our representative to the AMA Conference on Mental Health.

—endorsed the recommendation of the Epilepsy Project that would liberalize present laws with respect to the marriage of epileptics.

—adopted the following resolution concerning poliomyelitis vaccine:

1. We reaffirm our position in support of the State Department of Health in offering to provide Salk Vaccine free of charge for the immunization of eligible medically indigent patients.

2. We believe that the distribution of the State-provided vaccine should be limited to established clinics and health stations. In this way, needy patients who are eligible for immunization can be cared for at Baby-Keep-Well Stations, appropriate clinics at the various hospitals, and private physicians' offices.

3. We oppose the establishment of special clinics.

4. Where a change of major policy is concerned and where medical services are involved, we strongly recommend the advisability of consultations between governmental agencies and The Medical Society of New Jersey prior to the release of public statements involving the general health of the community.

—directed that the above resolution be made available to county medical societies.

—authorized Dr. Allman to attend the AMA Congress on Medical Licensure in Chicago in February.

—authorized the creation of a Labor and Industry Liaison Committee to review common problems in that field.

The Physician and the "Disability Freeze"

Whether you know it or not, you will soon be playing a role in a "disability freeze" program. This odd-sounding phrase has nothing to do with freezers or hibernation. It refers to a change in the law which allows a wage-earner, under certain circumstances, to maintain his social security rights even while he is earning nothing, provided that this results from disability. Originally, the monthly benefits under OASI* were computed on the basis of average earnings during the ten year period from age 55 to 65, so that the worker could start drawing those benefits when he was 65. The trouble was, however, that if the worker were disabled for medical reasons, during that entire period, he would draw nothing even though he had been paying into the fund for years. The amendment was aimed at correcting this deficiency in the law.

So before long you may be confronted with a paper which a patient will need filled out to get his benefits under this new law. There are reviewing officers of the Department of Health and Education and Welfare who have to decide whether the patient's non-earning status is due to a "medically determinable physical or mental impairment" and whether it is a "total" disability. And that is where you come in.

Under the new amendments if a wage-earner became totally disabled at age 60 his average monthly taxable earnings would be computed up to the time of his total disability and the period from age 60 to 65 would be

the "disability freeze period." Individuals under 65 who are now permanently and totally disabled and those over 65 who are now receiving benefit payments but who had been totally and permanently disabled for 6 months or more prior to age 65 may apply for a disability freeze period. All this is of vital importance to the applicant.

The Department of Health, Education and Welfare has established district offices throughout the state to administer this Act. The Federal Government has signed an agreement with the State of New Jersey to establish a state office of O.A.S.I.* which will be responsible for evaluating the disability claims of applicants. In New Jersey, the State Rehabilitation Agency has been designated by the Governor to provide the necessary services, the costs of which are defrayed entirely from federal funds provided by DHEW.* The State Rehabilitation Agency has had the longest experience in dealing with the disabled and in deciding if the applicant can be restored to remunerative employment by rehabilitation services. It is also equipped to supply these services to those disabled persons feasible for rehabilitation.

Let us now trace the procedure that an applicant for a disability freeze must follow. An application is made in one of the district offices of O.A.S.I.* An applicant is potentially eligible for a "disability freeze" period if his disability has existed for at least 6 months and if it will be prolonged or permanent and if it will prevent him from engaging in remunerative employment during his period of disability. Furthermore he must have 5 years of "covered employment" out of the previous 10 years and 1½ years of "covered employment" out of the 3 years preceding the onset of the disability. If the applicant is potentially eligible the proper forms are filled out. After signing the form authorizing release of medical information, he is then provided with a medical report form which he must take to his physician or to a hospital, clinic or other agency to complete as proof of the disability. This medical report is brief but the information must be sufficiently factual as to history, clinical findings and diagnosis to establish the nature and extent of the disability. Additional clarifying statements are welcomed. These completed medical forms are *not given to the applicant*. They are sent directly to the district office of O.A.S.I.* in an envelope attached for that purpose. The application with the completed forms is sent to the State Office of O.A.S.I.* for decision as to whether the applicant is permanently and totally disabled to return to employment by reason of a "medically determinable physical or mental impairment." The review team of the State Office of O.A.S.I. consists of at least a rehabilitation counselor and a State physician of the Department of Labor and Industry both of whom are trained in the evaluation of disabilities in relation to the ability to work. The decisions of the review team of the State O.A.S.I. are sent to and examined by a control office in Baltimore. This office can disallow the approval of the State O.A.S.I. review team if the medical information is insufficient or if the decision is not based on the medical standards set up by the Medical Advisory Committee of the Bureau.

Responsibility for obtaining the medical information lies with the applicant and not with the Bureau or State O.A.S.I. office. In some instances the review team may need additional reports of diagnoses and clinical findings from existing records and will tell the applicant to secure these at his own expense. A medical examination at the expense of the Government is authorized only in exceptional cases.

Experience shows that while most medical reports are satisfactory, too many contain insufficient medical findings to permit the reviewing physician to evaluate the extent and nature of the disability. If the four paragraphs in the medical form are adequately and legibly completed the information should provide the answer to the question, "Is the applicant disabled to such a degree that he has not been able to engage in remunerative employment." Diagnoses such as lumbago, rheumatism, neurosis, allergy or malignancy are not acceptable. Statements as to total disability or inability to work should be avoided. These decisions are made only by the review team whose conclusions are reached after all of the facts have been collected, considered and appraised. Other facts (not placed in the medical report) such as the work record, age, training and ability may influence the final decision. For example, a family physician may think a man is totally disabled after a correction of a herniated disc and a spinal fusion operation. However, a review team may decide to retrain him in a sedentary position through the Rehabilitation Commission. The review team will appraise an applicant in terms of what faculties and abilities "are left" and whether they can be applied in a suitable job which would enable the applicant to return to remunerative employment.

Henry A. Brodkin, M.D., Chief Medical Director
New Jersey Department of Labor and Industry.

*OASI means "Old Age and Survivors Insurance." DHEW means "Department of Health, Education and Welfare."

Announcements • • •

Aloha, Aloha

Treat yourself to a week or two in Hawaii in the springtime. Why not?

This invitation comes from the Hawaii Medical Association, celebrating its hundredth anniversary, April 22 to 29. There will be a short fact-packed, usable professional program on Monday and Tuesday mornings, a spectacular Centennial Celebration Pageant Tuesday night, and a traditional *Luau* (Hawaiian feast to you Jerseyites) Thursday night, with Polynesian entertainment.

April is the best time of the year to visit America's island paradise—clear, balmy days and cool, refreshing nights; spring flowers in profusion on the ground and in the trees; lovely island m—— but you have the idea now, surely. Hawaii in the spring is always a magnet. This is your chance to tie it into a professional meeting. It follows the American College of Physicians' session in Los Angeles, too. Write the Hawaii Medical Association, 510 South Beretania St., Honolulu 13, Hawaii, for reservations and details.

Dystrophy Center Now Open

A muscular dystrophy clinic under sponsorship of The Muscular Dystrophy Association of America is conducted at the Hospital for Crippled Children, 89 Park Avenue in Newark. The clinic meets each Wednesday morning and sees patients by appointment. Patients referred by private physicians or by other clinics will be seen for consultation and then referred back for treatment. Other patients may be admitted to the hospital for diagnostic study or treatment. The clinic is directed by Dr. Saul I. Firtel and is staffed by an orthopedic surgeon, a pediatrician, an internist, and a neurologist. For further details write to Dystrophy Clinic, 89 Park Avenue, Newark, or telephone MItchell 3-0820.

Cardiac Emergency Kit Available

A portable kit is now available containing equipment and drugs to be used in cardiac emergencies. The kit is only 16 inches long and 12 inches deep and weighs eight pounds when empty. Included is a brief outline of diagnosis and emergency treatment for 13 common emergencies, written by a New Jersey cardiologist. This kit will be found useful by general practitioners, ambulances, first aid squads and emergency rooms. The kit itself is available through the Essex County Heart Association, 120 Evergreen Place, East Orange, at $15, which includes the case, the partitions and the special grips for holding the drugs, as well as a list of drugs and equipment which should be inserted.

Symposium on Crash Injuries

Automobile accidents will be considered as a public health problem in the Biggs Memorial Lecture of The New York Academy of Medicine, to be presented on Thursday, February 2, 1956 at 8:30 p.m. There is no fee. The meeting will be at 2 East 103 Street, New York City.

First speaker will be John O. Moore, Director of the Crash Research Project at Cornell University. Mr. Moore will describe the epidemiology of automobile accidents as it has been revealed by intensive field studies in several states.

Dr. Herbert J. Stack, Director of the Center for Safety Education at New York University, will speak on "The Psychology of Drivers."

Traffic conditions as seen by a safety expert in the insurance business will be discussed by Paul H. Blaisdell, Director, Traffic Safety Division, Association of Casualty and Surety Companies, New York.

New York's Commissioner of Traffic, T. T. Wiley, will review the engineering features involved in the traffic situation.

Obituaries • • •

DR. MAURICE BLAUSTEIN

Dr. Maurice L. Blaustein was in the first group of doctors to intern at the Newark Beth Israel Hospital. He was graduated from the medical school of Columbia University in 1919. Born in upstate New York in 1895, he came to New Jersey following his graduation from medical school and soon became affiliated with the staffs at St. Michael's and St. Barnabas Hospitals. Dr. Blaustein was a family doctor. He died in Newark on November 5, 1955.

DR. HYMAN FRIEMAN

Born in 1905, Dr. Hyman Frieman, past president of the Bayonne Medical Association, died in the Bayonne Hospital on September 19, 1955. A lifelong resident of that community, he was city physician in the 1930s. Dr. Frieman was graduated from the medical school of New York University in 1929. He was a general practitioner affiliated with Bayonne Hospital.

DR. ALFRED A. MUTTER

Dr. Alfred A. Mutter, an emeritus member of the Hudson County Medical Society as well as The Medical Society of New Jersey, died on September 26, 1955.

Born in Irvington, Dr. Mutter was graduated from the Medical School of the University of Louisville in 1905 and started practice in Kearny, N. J. in 1906. He was one of the founders of the West Hudson Hospital and on the staff of the Presbyterian Hospital of Newark. For many years he was surgeon for the Erie Railroad. He had an extensive general practice in West Hudson from 1906 until his retirement in 1951. Dr. Mutter was in the Medical Corps of the Army in World War I, and a member of the Draft Appeal Board during World War II.

DR. BERT A. PRAGER

One of Chatham's senior physicians died on November 28, 1955 with the passing on that date of Dr. Bert A. Prager. Born in New York in 1884, Bert Prager earned his M.D. at the Long Island College Hospital in 1908. He interned at Bellevue in 1908-9, and came fresh from his internship to the then rural village of Chatham. There he set up his office for general practice, and there he remained for almost half a century, ministering day and night to the medical needs of suburban Morris County. For many years he was the boro's police surgeon, and he was active in Masonic circles.

DR. IRA T. SPENCER

In 1950, this Medical Society selected Dr. Ira T. Spencer as the "physician of the year." In 1955, on November 22, Dr. Spencer, at the age of 84, died at the Rahway Hospital, an institution he had helped organize.

In 1871—when Ulysses S. Grant was President—Ira Spencer was born in Somerset County, New Jersey. He received his M.D. from the University of Pennsylvania in 1893. The next year he established his practice in Woodbridge, and he served that Middlesex County community faithfully for 60 years. He helped establish the Rahway Hospital and for some years was president of its medical staff. He was also affiliated with the Perth Amboy General Hospital. Dr. Spencer was active in civic affairs, serving as an officer, at one time or another, of the Country Club, the Elks, the Volunteer Firemen, the Rotary Club and other organizations. In 1929 he was elected president of the Middlesex County Medical Society.

DR. ARTHUR P. TREWHELLA

One of Hudson County's most useful citizens passed away on November 28, 1955. As he would have wanted, Dr. Trewhella died in harness—died while making a call. Only 49 years old, he was vice-president of the Hudson County Medical Society and was the incoming president of our New Jersey chapter, American Academy of General Practice. Until recently he was editor of the *Bulletin* of his county medical society and had just been re-appointed Physician to the Boulevard Police Department.

Born in Jersey City, Dr. Trewhella was graduated from Georgetown in 1929. After a 2-year internship at the Jersey City Medical Center, he went into private practice. Always active in civic and in medical organizational affairs, he held many posts in civic and medical groups.

DR. FRANKLIN C. YOUNG

After a long illness, Franklin Young died at his home in Summit on November 27, 1955. Born in Vermont in 1891, Dr. Young earned his M.D. at the medical college of the University of Vermont in 1913. After interning in Dartmouth, N. H. he joined the U. S. Army and served first as a lieutenant, later as a captain in the medical corps. He went to France in 1917 with the famed Rainbow Division.

On being mustered out in 1919 he came to New Jersey and he lived in our state ever since. He was in general practice in Morristown from 1920 to 1932 and then moved his office to Summit. Although essentially a family doctor, Dr. Young was particularly interested in urology and was on the urologic service at the Overlook Hospital.

Authors' Clinic • • •

Case Histories: Write, Don't Telegraph

"Female, white, admitted 6/16/55, 3 months after attack of headache. Family history negative. RBC 4,000,000. Hbo 67%. Rigid abdomen . . ."

This is not writing. It is telegraphy. It exhausts the reader just to look at it. A case report should flow smoothly. It is made up of sentences. And every sentence, remember, has to have a verb in it somewhere. Thus:

"Right lower quadrant tender, rigid. Other quadrants normal. Kernig sign positive, Brudzinski negative."

This looks like three sentences. But there isn't a verb in the lot. It's not three sentences. In fact, it's not even English. It's telegraphese. Put in the verbs so that this dyspneic paragraph becomes English:

"The right lower quadrant was tender and rigid, but the other abdominal quadrants were normal to palpation. The patient had a positive Kernig sign but the Brudzinski was negative."

The case report is the basic building block of medical literature. Every editor is hungry for unusual or instructive case reports. It is not necessary to review the entire literature of sarcoidosis to report one case. The editor's appetite isn't that big. What he wants is the unadorned report of the unusual case, plus a few lines of comment. It is pretentious to detail three cases of athlete's foot and then use that as a platform for a 10,000 word monograph on dermatology.

Tell them first what the case is all about and why it is worth reporting. Then, right in the middle of the page, in capital letters you write like this:

CASE REPORT

If more than one case is being reported, you write CASE ONE instead of CASE REPORT. The editor usually sets case reports in smaller type. But that does not mean that you may single-space the copy. Far from it. Since a case report requires a lot of editing, you had better have your secretary double-space or triple-space it.

It is so easy to bungle a case report, that it is a good idea to review first this list of things not to do.

Do not give hospital case numbers, serial numbers, admission numbers and the like. If you want the hospital number for reference purposes, write it on your retained carbon copy. But don't include it in the manuscript sent to the editor.

Do not use the patient's initials. This serves no purpose. It may get you into trouble because a sensitive patient named Josephine Zilch would feel that J. Z. identifies her as easily as her picture. She may be wrong, but she can embarrass the author by insisting that initials fail to conceal her identity. So, omit the patient's initials. You don't need them except, maybe, for your own private reference purposes. For that, write the patient's name on your personally retained carbon copy.

Omit the name of the referring physician unless there is some very persuasive reason for including it. Common courtesy is, sad to say, an insufficient reason. If you really want to accolade the referring physician, make him a co-author. Or append a little note like "The author acknowledges the assistance of Dr. Theophrastus Perrywinkle, the family physician of the patient here described."

Do not slavishly copy laboratory, operative and autopsy reports. These documents were written for hospital, not for publication purposes. Believe it or not, an otherwise intelligent surgeon recently submitted a case report to the JOURNAL which included this incredible paragraph:

"The patient was placed on her back on the operating table and draped for a laparotomy. The skin was painted with . . ."

—and so on, describing a normal appendectomy, blow by blow. He finally got to the point—the discovery and drainage of an abscess in the tube. When the editor struck out everything before the description of the tube operation, the author was indignant. He had copied the operative report verbatim and felt that there was something sacrilegious in editing it. Similarly a laboratory or autopsy report is usually loaded with negative and insignificant findings. The author must squeeze all these out of his manuscript.

This brings up the question of negative and normal findings. The rule is simple: never include a negative or normal finding unless it

is indispensable to an understanding of the case. If a patient is getting a drug which often produces an eosinophilia, it is significant to point out that the eosinophil count was normal. But except under such conditions, it is wasteful to recite a normal blood count. A good author goes over the case report several times and removes mention of the patient's height, weight, blood count, respiration count, pulse and so on, unless the data contributes materially to an understanding of the case. When in doubt, take it out.

It is surprising how much past history can be omitted without hurting an understanding of the case. Is it really important now that his father was killed in automobile accident, that he had the "usual childhood diseases?" With any such item ask yourself honestly: is this phrase necessary? When in doubt, take it out.

Write consistently in the past tense. This will require you to change the tense of laboratory, x-ray, operative and autopsy reports. Suppose, on the hospital record it reads like this:

"The patient complains of pain in the neck. He developed this yesterday while watching a tennis game. Examination today shows tenderness along the . . ."

In writing this as a case report for publication, you change the verb to the past tense, so:

"On admission he complained of pain in the neck. He first developed this pain the day prior to admission, while watching a tennis game. Examination, on admission showed tenderness . . ."

Note that "complains" and "shows" in the hospital record became "complained" and "showed" in the case report. So, in an autopsy report, the pathologist may say "The heart weighs 365 Grams." In the published case report, "weighs" would be changed to "weighed."

Avoid abbreviations. Nothing will so infuriate the editor as an unacceptable abbreviation crowded into single space copy. Since you may not be sure about the acceptability of abbreviations, the only safe rule is spell everything out. Spell out "30 cubic centimeters" and not "30 c.c." Write "polymorphonuclears" rather than "polys," and "red cells" rather than "RBC." Use "per cent" never "%." Write "family history" not "FH" and write "hemoglobin" rather than an abbreviation.

Laboratory reports are written smoothly, a verb in every sentence. This is gibberish: "Blood ct.: 7500 WBC; 3,000,000 RBC. Polys 75%. Urine neg. CSF normal." Write it out, and include the verbs: "White cell count showed 7500 leucocytes; 75 per cent of these were polymorphonuclear cells. The red cell count was 3 million. Urine and spinal fluid studies were normal."

Make no mention of the color of the patient unless that information is indispensable in understanding the case.

If the case report covers more than three or four paragraphs, you may use side headings. These should be underlined so that they will appear as italics in print. The side headings, in your typed copy, are set up like this:

CASE ONE

A 45 year old man came to the clinic complaining of "seeing triple." This symptom had started three days earlier when . . . no relief, he reported to our clinic.

Family History: His mother, still alive at age 80, was described as "having had sick headaches all her life." The father had poor vision, and the patient had been told that "weak eyes ran in the family." One brother . . .

Personal History: At the age of 13, he . . .

Do not give actual admission or operation dates. This makes it too easy to identify the patient and may cause embarrassment. Orient everything to one, or to a few, time base-points. These usually are the day of admission and the day of operation (or delivery). Thus: "Five days prior to admission, x.y.z. happened" . . . "On the fourth day after admission, he passed the stone." . . . "Ten hours after the operation, he voided bloody urine." . . . "On the fourth post-operative day, this happened." . . . "He was discharged from the hospital ten days after admission on the eighth post-operative day" . . . "Fourteen days after discharge, he died." If dates must be used (and try to avoid them), say "May 27, 1955" rather than "27 May 1955." The war is over. We hope.

— Henry A. Davidson, M.D.

Letters to The Journal • • •

Blue Shield and Office Procedures

Dear Sir:

In the October issue of THE JOURNAL of The Medical Society of New Jersey there were two items pertaining to the Blue Cross. One was comment of the editor [1] and the other[2] was a "Memo from Blue Cross." Both inferred that the medical profession was abusing the Blue Cross with unnecessary and unnecessarily prolonged hospitalization.

Please stop aiding the non-medical press in the campaign against the present day practice of medicine.

It is my suggestion that the Blue Cross, by the nature of its contracts, brings the dilemma upon itself. To illustrate: Mrs. X came for insufflation of her tubes in hope that this would aid her becoming pregnant. She had Blue Cross and Blue Shield coverage. The insufflation was done in the office. A claim for it was refused by the Blue Shield because the patient was not hospitalized. Believe me, the patient was confused when she had to pay $15 out of purse while her insurance policy promises indemnity if she is hospitalized unnecessarily. If this procedure must be repeated, it is evident that the patient will insist upon it being done in the hospital. Will the doctor be wrong in doing so?

Members of The Medical Society of New Jersey are doing a fine job. This job is being done in spite of the bewildering maze of contractual agreements on the part of hospitalization and medical-surgical indemnity companies.

Very truly yours,

William F. Thornley, M.D.

Dear Sir:

In his letter, printed above, Dr. Thornley cites a case of insufflation of tubes as evidence that over-utilization of Blue Cross and Blue Shield benefits is due to the provisions of their own contracts. We would point out that this was evidently an elective procedure in this instance. It is a relatively uncomplicated, inexpensive procedure that would ordinarily be done in the doctor's office.

The Blue Shield Subscription Contract is intended primarily to provide protection against serious, expensive, emergent conditions. As a general rule, such conditions are treated in hospital. Hence, except for emergency surgical service occasioned by an accident, obstetrical delivery, and removal of tonsils and adenoids, the Blue Shield Contract limits benefits to hospitalized medical and surgical conditions and emergency surgical service in the out-patient department.

If the Blue Shield Plan were to provide payment for all types of medical and surgical care that are ordinarily rendered patients in their homes, or as ambulatory patients in the doctor's office, it would be necessary to charge a greatly increased premium for such coverage. Blue Shield would price itself out of its market, and many present subscribers would discontinue their coverage or would substitute commercial contracts that provide less comprehensive benefits and lower payments to the physician.

Blue Shield cannot cover everything. The Plan must depend upon the cooperation of physicians in discouraging unnecessary hospitalization for the sole purpose of collecting benefits from both Blue Cross and Blue Shield for services that do not require hospital care and would ordinarily be ineligible for the benefits of either Plan.

Blue Cross and Blue Shield presently constitute the source for payment of a substantial part of services rendered by the hospitals and the medical profession. When these Plans are exploited, the voluntary hospital system and the independent medical profession are in jeopardy. We are happy to acknowledge the consistently fine and intelligent cooperation we have received from the overwhelming majority of physicians.

Sincerely yours,

NICHOLAS F. ALFANO, M.D.,
Associate Medical Director

1. Page 493.
2. Page 539.

County Society Reports • • •

Atlantic

The regular meeting of the *Medical Society of Atlantic County* was held at the Children's Seashore House, October 14, 1955. The president, Dr. Peter H. Marvel, presided.

Dr. Bernard P. Widmann, Professor of Radiology at the University of Pennsylvania, opened the discussion of "Cancer of the Cervix." He showed that by planning and development of the present system of treatment, the survival rate has gradually improved.

The discussion was continued by Dr. Francis H. Carter of Duke University.

The business meeting was opened with the approval of the previous meeting as published in the *Bulletin*.

The following Committee reports were received:

1. *Committee for the Diamond Jubilee Celebration*—Dr. Diskan, Dr. Erskine and Dr. Merendino pleaded for full cooperation in making the dinner a success.

2. *Censorship Committee*—Dr. Molitch, reporting for Dr. Harley, stated the following were elevated from associate to regular membership: Dr. Marvin Barnett, Dr. Donald C. Davidson, Dr. James C. Hitchner, Dr. Earl I. Kanter, Dr. Robert L. Krasney, Dr. Arthur A. Lee, Dr. John M. Levinson, Dr. Joseph D. McGeary, Dr. Paul H. Steel.

3. *Welfare Committee*—Dr. Stamps reported his committee was active at the state level. At the meeting held in Trenton, Dr. Allman gave the committee a report from the national level. Dr. Allman reported briefly concerning future legislation.

Following the meeting, entertainment and refreshments were enjoyed by the members of the Society and the Woman's Auxiliary.

LEONARD B. ERBER, M.D.
Reporter

Camden

Dr. A. G. Pratt, president, opened the regular monthly meeting of the *Camden County Medical Society* on November 1, 1955. Dr. Samuel V. Geyer was introduced after taking the membership oath. Members William Halbeisen, Robert L. Beckenridge, Francis Meidt, Edwin N. Murray, William Most, and Natalija Musulin participated in a well received "Case Night Program". Two nominees were elected to fill vacancies created by the untimely death of Dr. H. Wesley Jack. The new District Judicial Council representative is Dr. Edmund C. Hessert. Dr. James R. Eynon becomes a Delegate to the State Society. A motion was passed to explore the pros and cons of Social Security for physicians. The Society will be polled later. Dr. Thomas M. Kain, Jr., Chairman of the County Rheumatic Fever Committee, informed the meeting of advances in the preventive and detection fields that his group has made. Dr. Kain spoke of a pilot study now in progress in one of the Camden schools.

FREDERICK W. DURHAM, M.D.,
Reporter

Gloucester

On November 24, 1955, the *Gloucester County Medical Society* held its regular meeting, with the president, Dr. William Beall in the chair. Dr. Guy Campo introduced the speaker of the evening, Dr. Carl Fischer, whose talk was entitled "A Plea for the Adolescent." Dr. Fischer is Professor of Pediatrics at the Hahnemann Medical College in Philadelphia.

At the following business session, there was general discussion of the methods of distributing the poliomyelitis vaccine. The suggestions made by The Medical Society of New Jersey were read, reviewed and considered. The resolution finally adopted by the Gloucester County Medical Society put this society on record as endorsing Salk vaccine, favoring its wide distribution and pledging cooperation with local Boards of Health.

There was also presented a report, from Dr. Samuelson, on disaster control in Golucester County. The meeting adjourned at 11:45 p.m.

R. D. LOVELACE, M.D.
Reporter

Hudson

Hudson County Medical Society convened in regular monthly session on November 1, 1955, at Jersey City Medical Center. Dr. Sigmund C. Braunstein presided.

Dr. Sidney Woltz reported on arrangements that have been made for the observance of Diabetes Detection Week in Hudson County. Approximately 15,000 St. Louis Dreypaks are being distributed throughout the county.

Members of the Society were advised to add the *Extended Professional Disability Policy* (as offered by E. and W. Blanksteen) to their basic policy. Members nearing their sixtieth birthday were urged not to let this enrollment period pass

without giving due consideration to this extended policy.

The following physicians were elected to active membership: Drs. Alexander Cataldo, Nicholas Chylak, Joseph Fiore, and Corrado Fraraccio, of Jersey City; Drs. Mario Bello, John J. O'Connor, and Anthony R. Picollo, of Union City; and Dr. Olindo W. Rosanelli of West New York.

The Society adopted regulations to govern the future administration of the Physicians' Relief Fund of Hudson County Medical Society.

At the Scientific Session, the guest speaker was Dr. Kathleen E. Roberts of the Department of Medicine, Research Assistant at Memorial Center and Cornell University Medical College, and Assistant Attending Physician at Memorial Center, New York City. "Electrolytes" was the subject of Dr. Roberts' scholarly presentation.

CHARLES A. LANDSHOF, M.D.

Reporter

Middlesex

The regular monthly meeting of the *Middlesex County Medical Society*, November 16, 1955 was held jointly with the County Pharmaceutical Association at Oak Hills Manor, Metuchen, N. J.

The report of the Judicial Medical Ethics Committee by Dr. B. F. Slobodien, Chairman, presented the application for re-instatement to regular membership from Dr. Carmine Falcone, New Brunswick. Also announced were applications for promotion to regular membership from associate membership for: Dr. W. Errgong, Highland Park, Dr. H. B. Fein, South River, Dr. Thomas I. Steinberg, Metuchen and Dr. S. Sklar, Highland Park.

Applications for associate membership were received from Drs. Francis J. Godrey, New Brunswick; Bernard Boodin, Fords; Julian Mandell, Perth Amboy; Michael O'Kane, Metuchen; and Vincent Pidota, Metuchen.

The President then read several communications regarding Salk vaccine, and asked the wishes of the members. It was the unanimous opinion of the members present, that we endorse the report of the Board of The Medical Society of New Jersey with reference to poliomyelitis vaccination in New Jersey. Considerable discussion followed. A motion by Dr. Marshall Smith suggested that a statement be prepared for release to the public *via* radio and newspapers. This statement was amended to delete the portion pertaining to pregnant women.

A letter from the Hospital-Service Plan of New Jersey indicated that although 51 per cent of the physicians of the County had not availed themselves of the Plan, those that had indicated their interest would soon receive coverage.

The joint meeting (physicians and pharmacists) was then opened and after proper introductions and eulogies, a buffet supper followed and was concluded with a welcome of the President of the Pharmaceutical Association, as well as introductions of the officers of the Medical Society.

The session was brought to a close by the delightful entertainment of Marian Page, who showed excellent form and superb rapport bringing out the hidden talents of some of the neophite comedians in the Medical Society.

The meeting was adjourned at 12:45 a.m.

ALFRED J. BARBANO, M.D.

Reporter

Monmouth

The regular monthly meeting of the *Monmouth County Medical Society* was held at Monmouth Memorial Hospital, Long Branch, on October 26, 1955 with Dr. William F. Jamison, the President, presiding.

Elected to active membership were Dr. Edwin Morris, Red Bank and Dr. Charles H. Schutt, Lincroft. Dr. N. Allen Norman, Elberon, was elected to associate membership.

Following the business meeting, an interesting panel discussion was held on "Upper Gastrointestinal Bleeding." Dr. Leon Ginzberg, Director of Surgery, Beth Israel Hospital, New York, headed the panel. Drs. Daniel Featherston and Joel Feldman completed the panel, and Dr. Peter Guthorn served as moderator.

DONALD W. BOWNE, M.D.

Reporter

Morris

The regular meeting of the *Morris County Medical Society* was held at the Warner Chilcott auditorium in Morris Plains on Thursday, November 17, 1955. Dr. Harold Hatch presided. Dr. Maxwell Chamberlain discussed "New Frontiers in Aortic Surgery" and showed motion pictures depicting the surgical resection of the aorta for congenital anomaly and for multiple aneurysm. Following the clinical presentation, the business meeting was opened with the reading of the secretary's minutes.

The recent decision of the executive committee against the promiscuous free administration of anti-polio vaccine regardless of the ability to pay was discussed.

Dr. William Costello, one of the elder statesmen of the Morris County Medical Society and indeed of The Medical Society of New Jersey, then rose and offered a resolution that the Morris County Medical Society seek the nomination of Dr. F. Clyde Bowers, one of its outstanding members, for second vice president of The Medical Society of New Jersey. This resolution was received with enthusiasm and unanimously acclaimed.

ALBERT ABRAHAM, M.D.

Reporter

Passaic

The regular monthly meeting of the *Passaic County Medical Society* was held October 18, 1955, at the Medical Society Building. Dr. Jehl, the President, presided.

The following physicians were elected to membership: Active member—Dr. Robert V. Holman of Clifton; associate members — Dr. John Duff Brown of Pompton Plains and Captain Harold Mondragon of New York City.

The following resolution was adopted:

WHEREAS: It has pleased the Almighty God, in His infinite wisdom, to take unto Himself Dr. Charles A. Keating, an Emeritus Member of the Passaic County Medical Society, and

WHEREAS: Dr. Charles A. Keating has labored long and faithfully as a Gynecologist in the City of Paterson and in his later years had established a wonderful reputation as an expert in compensation cases,

BE IT RESOLVED: That the Passaic County Medical Society deeply regrets the passing of its esteemed member, and extends its sincerest sympathy to the bereaved family, and

BE IT FURTHER RESOLVED: That these resolutions be spread in full in the minutes of the Passaic County Medical Society, and a copy be sent to the family of the deceased.

Charles J. Murn, M.D.
Alvin E. Cortese, M.D.
A. M. Schultz, M.D.

Dr. Francis R. Palmer then spoke in connection with the stand of the A.M.A. on Social Security. A short discussion followed.

Resolutions of the New Jersey Ophthalmological Society were read. These concerned the ethics of supplying eyeglasses and ophthalmologic-optometric relationships.

The President again urged the members to join the Widows and Orphans Society; to buy automobile medical emblems and to send in the questionnaire with reference to telephone coverage and other data required for office record.

Dr. Jehl then turned the meeting over to Dr. Robert H. Joelson who introduced the speaker, Henry Dolger, M.D., Physician in Charge of Diabetic Clinic, Mt. Sinai Hospital, New York. Dr. Dolger's topic was "Diabetic Patients and Their Foibles."

The regular monthly meeting of the *Passaic County Medical Society* was held November 15, 1955 at the Valley View Hospital. Dr. Joseph R. Jehl, the President, presided.

The following were elected to active membership: John J. Bowe of Oradell; Edward C. Bressler and Saul Siegendorf of Passaic; Carmine D. Diorio and Albert Van Eerde of Paterson. Elected to associate membership were: Archie Handler, Passaic, and Samuel M. Schlyen of Rutherford.

The following was adopted by the majority of the members present:

Immunization against poliomyelitis is a goal which is favored by the medical profession.

No patient who cannot afford to pay for this immunization should be denied its benefits.

Such an immunization program, however, rightly belongs within the province of the private practice of medicine and should remain so, thus retaining the patient-doctor relationship. There is no reason why those who are willing and able to pay for it, should be offered or invited to receive this service free-of-charge in clinics or schools.

In view of the responsibility of the physician who administers the vaccine, and the medical judgment which should be exercised in its administration to children with existing physical disability or disease, it is the consensus of the Passaic County Medical Society that any public program of poliomyelitis vaccination should be limited to Health Department Immunization Clinics established primarily for medically indigent patients.

The Passaic County Medical Society urges all doctors to cooperate with such a program, but goes on record as being opposed to any other method which it regards as contrary to the American System.

Dr. Jehl then turned the meeting over to Dr. Homer H. Cherry who introduced the guest speaker, Avron Y. Sweet, M.D., Medical Director of the Poliomyelitis Respiratory Center, Mt. Sinai Hospital, New York City. Following Dr. Sweet's lecture, a short question period was held.

DAVID B. LEVINE, M.D.
Reporter

Salem

After a talk on antibiotics by Dr. Carl Fisher, the *Salem County Medical Society* discussed the problem of distribution of the Salk poliomyelitis vaccine. This was at the regular meeting on November 19, 1955. The Society felt that the program as suggested by the State Department of Health was at variance with that urged by The Medical Society of New Jersey.

CHARLES E. GILPATRICK, M.D.
Reporter

Widows and Orphans Society

The Trustees of *The Society for the Relief of the Widows and Orphans of Medical Men of New Jersey* held its Annual Meeting on November 30, 1955, for the purpose of distributing funds to needy widows and orphans of deceased members. Those are gifts other than the money sent to a widow or orphan directly after the death of the member. Recently two of the widow beneficiaries passed away at an advanced age after many years of partial support by our organization.

It was unanimously voted to give the entire income from the permanent fund to those needy people in four installments throughout the next year, and in addition to these, a Christmas check.

If any member knows of any widow or orphan of a deceased member who falls into this category, please notify the undersigned.

HERBERT M. ILL, M.D.,
Secretary

Auxiliary Report • • •

Essex

The *Snow Ball,* a delightful dinner-dance was held by the *Woman's Auxiliary to the Essex County Medical Society* on December 7, 1955, at Mayfair Farms, West Orange. Mrs. William D. Miningham, Jr., acted as chairman. A winter holiday theme prevailed with decorations consisting of snowballs, Santa's sleigh, and gay red Christmas candles lighting each table.

Dr. Jerome Kaufman, president of the Essex County Medical Society as Master of Ceremonies introduced the honored guests: Dr. and Mrs. Christopher A. Beling, Dr. and Mrs. Marcus Greifinger, Dr. and Mrs. Ralph R. Autorino, Dr. Kenneth Gardner, second vice-president of The Medical Society of New Jersey, and Mrs. Harry E. DiGiacomo, president-elect of the Essex Auxiliary. Mrs. Autorino introduced Dr. and Mrs. William D. Miningham, Jr., and Mrs. H. Roy VanNess, president of the Fellowettes, a society composed of past presidents of the Essex Auxiliary. The honored guests and Dr. and Mrs. Harrold Murray and Dr. and Mrs. Frank S. Forte formed the receiving line.

Special features of the dance included: A Skater's Waltz, the Mexican Hat Dance, and the Charleston. These were actively participated in by the guests. Climax of the evening was the selecting and crowning of a Snow Queen. Dr. Kaufman selected the lucky snowball from the sleigh which named Mrs. Asher Yaguda as Queen. Mrs. Philip R. D'Ambola, chairman of the entertainment committee, crowned the queen.

On November 28, Mrs. Ralph R. Autorino presided at the Executive Board Meeting and regular meeting of the Essex Auxiliary held at 369 Park Avenue, West Orange. Mrs. George Parell, program chairman, presented Dr. Thomas L. Ormsby, Chief of the Medical Chest Clinic at St. Michael's Hospital in Newark, who spoke on tuberculosis.

After the business meeting a fascinating talk on the history of some of the world's most famous diamonds was given by Miss Mary R. James. After the meeting tea was served with Mrs. Michael J. Hyland and Mrs. Chester Modeski as hostesses.

MRS. CHARLES J. CALASIBETTA,
Chairman Press and Publicity
MRS. EDWIN H. ALBANO,
Co-chairman

Book Reviews • • •

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

Suggested Antidotes. American Pharmaceutical Association, Washington, D. C. 1955. Paper. Pp. 32. Price $0.40. Lower prices in quantities.

Suggested Antidotes is a life-saving manual which may be found at most pharmacies. Stored in the pocket in the back cover of *National Formulary X*, it provides a ready source of information for pharmacists and physicians. The manual speedily identifies the toxic ingredient and proper antidote for accidental poisoning. A physician who is suddenly faced with a child who swallowed soldering flux, for example, can quickly discover here that the toxic ingredient is probably hydrochloric acid and would therefore not make the (possibly fatal) mistake of giving vinegar but would give milk of magnesia or aluminum hydroxide gel instead. Simply skimming the list brings several interesting facts to light, *e.g.*, the toxic ingredient of many dyes is acetanilid; liquid petrolatum is useful in preventing liver damage in carbon tetrachloride ingestion; and nicotine is a toxic agent in some insecticides. There are cross-indexes for nail-polish, paint, permanent-wave hair solutions, paris green, and rust preventives, to name just a few more of the commonplace items in the remarkably complete listing. Although not intended to take the place of more comprehensive reference works on the subject, the pamphlet is outstanding in its practical approach and its ready availability.

Not only does it provide the specific antidote for the identified toxic ingredient of an accidental poisoning, but the brochure also gives the directions for preparing a "universal antidote," useful in poisoning by acids, alkaloids, glycosides, and the heavy metals. A space for emergency information is provided for such important data as: local police emergency squad, and nearest Poison Information Center.

Suggested Antidotes should be included in every physician's library and familiarity, if not indeed in every doctor's bag.

IRVING D. ROSENBERG, M.D.

Fluid Therapy. By James D. Hardy, M.D. Pp. 255. Philadelphia, Lea & Febiger, 1954. ($5.50)

Water balance! Electrolytes! Milliequivalents! These terms set up a mental block in the mind of many physicians. With a regretful shrug of the shoulder they say in effect, "That's too difficult for me."

In the preface to this book appears the following statement: "The purpose in writing this volume has been to present a concise discussion of total fluid therapy." In the opinion of this reviewer, Dr. Hardy has succeeded in his purpose. Some subjects would seem to merit a more detailed discussion than given; on the other hand, it would defeat the original intention to present the principles of fluid therapy in broad outline. The book contains basic information presented in simple language. Beginning with a general consideration of the physiology of body fluid metabolism, the author then briefly refers to methods of measurement. This is followed by a classification of the various states of imbalance and discusses the recognition of these states.

The latter part of the book deals with the problems of management in commonly encountered surgical and medical conditions. Fluid and electrolyte replacement in the therapy of burns and acute hemorrhage are also considered. A final chapter discusses some of the complications attendant upon intravenous therapy.

"Fluid Therapy" was not intended to be an exhaustive treatise on the subject, but it contains many valuable pointers and much practical information relating to problems encountered in every practice. It would be a valuable addition to one's medical library.

GEORGE L. ERDMAN, M.D.

Surgery of the Ambulatory Patient. L. Kraer Ferguson, M.D. Ed. 3. Philadelphia, Lippincott, 1955. Pp. 866. ($12.00)

Patients with "minor" disorders get lost in the maze of those with major or more glamorous conditions. No one really is a specialist in ambulatory or outpatient surgery. The hospital surgeon scorns it as beneath his dignity, while the general practitioner and the internist consign it to surgery. Result: doctors are ill-prepared to deal with ambulatory surgery.

Here is where this unique book, just released in a new third edition, comes to the rescue of the general practitioner and the patient. Dr. Ferguson reviews the equipment (including furniture as well as instruments) needed for outpatient surgery. His colleague, Professor Stone discusses anesthesia. The subjects of dressings, first aid and bandages are reclaimed for the physician. (By default they have been going to the lay first-aid man.) The author then reviews the handling of burns, foreign bodies, abscesses, infection, frostbite, cysts and the like. The second part of the book takes us on a tour through the regions—the scalp, the eyes, the neck, the chest, the back, the abdomen, the hands, and so on. There is a special section on fractures.

The book is a veritable office encyclopedia for the family doctor and for the beginning surgeon. And, one suspects, even the long-experienced surgeon will find it helpful to dip into it now and then.

VICTOR HUBERMAN, M.D.

National Formulary: Tenth Edition. Published by the American Pharmaceutical Association, Washington, D. C. 1955. Pp. 867. ($9.00)

It should be unnecessary to write a lengthy review about the National Formulary. Together with the U. S. Pharmacopoeia this constitutes Medicine's basic book of medicine. The Formulary contains a brief monograph of every item included, together with material on solubility, identification, packaging, storage, and frequently dosage. In an appendix there is a list of general tests, processes, apparatus, and useful tables. To the doctor who takes his prescription writing seriously, this book is an essential working tool.

HENRY A. DAVIDSON, M.D.

Coronary Heart Disease in Young Adults. By Menard M. Gertler, M.D., and Paul D. White, M.D. Pp. 218. Harvard University Press, Cambridge, Massachusetts, 1954. ($5.00)

This is a summary of research of a group of 100 patients with myocardial infarction sustained at the age of 40 or below. They were compared with a control group of 97 patients matched for age, height, weight, body build, race and occupation.

The book is well written and detailed and covers many details of information relative to clinical data, heredity, race, physique, athletic activity and occupation, masculinity, endocrine findings, and biochemical findings. Much of this is known to the informed cardiologist, but to find the same factors interplaying in such a large select group of young adults is really enlightening. In addition to a searching analysis of the subject, the book has an exhaustive review which is of great value. It is the hope of the authors that such exhaustive study and followup taking many factors into consideration will give the physician greater tools for preselection so that if or when preventive procedures are available they might readily be applied.

MARVIN C. BECKER, M.D.

Differential Diagnosis. The Interpretation of Clinical Evidence. By A. McGehee Harvey, M.D., and James Bordley, M.D. Pp. 665. Philadelphia, Saunders 1955. ($11.00)

This unique volume does not presume to be a text book but rather a "method of approach" to the diagnosis of disease. As Cabot stated, "All diagnosis must be differential before it can be of any use." Hence this book called Differential Diagnosis is aptly subtitled the "Interpretation of Clinical Evidence."

Fourteen topics that elucidate important diagnostic principles have been arranged in as many chapters each supplemented by illustrative cases. These constitute clinical studies carried out primarily during the last ten years and represent in most part the basis of the weekly clinical-pathologic conferences at Johns Hopkins.

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This is a new approach in differential diagnosis emphasizing by means of clinical-pathological case records the two important diagnostic procedures; i.e., collection of and analysis of the factual data presented. It will prove a valuable reference for internist and general practitioner alike.

EDWARD C. KLEIN, JR., M.D.

Practitioners' Conferences. Edited by Charles Forkner, M.D. New York. Appleton-Century-Crofts 1955. Pp. 411. Price not stated.

The volume originates a pioneer educational program for physicians unable to attend formal conferences or keep up with the recent medical literature. The book is not intended only for general practitioners as the title would imply. Outstanding authorities contribute concise opinions and make these conferences a source of interest even to the specialist. The topics covered in this first volume are of unequal interest and value. It includes a lengthy discussion of influenza and related upper respiratory infections. Diagnostic methods, the value of chemotherapeutic agents and vaccines, complications and epidemiology are adequately reviewed.

The physiologic and harmful effects of tobacco are discussed in the second conference. The false claims prevalent in advertisements are deplored. The filters lately in vogue are found to be ineffective in blocking the vascular changes induced by nicotine. Many other interesting facts of this problem are emphasized. The third conference is a practical review of the comparative value of the newer drugs in the therapy of malignant diseases as well as an outline of specific treatments. An otherwise good chapter on coronary thrombosis leaves many controversial points unsolved. Sections devoted to sinusitis and nodules in the breast are of limited value.

Three excellent conferences are limited to the discussion of poliomyelitis. Home care is stressed. Clear outlines are drawn as a help to physicians called upon to treat home cases in selecting the ones to be hospitalized. Emotional and physical rehabilitation are given their proper places. The present consensus in the treatment of tuberculosis is again formulated by authorities. Dr. Harold G. Wolff has contributed a lot to clarify the diagnosis and treatment of the headaches we constantly face in our practice. The two major schools of thought are represented in the conference dealing with diabetes mellitus and an effort is made to bring up the unformulated similarities between the two views. The last conference is the least attractive.

Dr. Forkner should be congratulated for conceiving and initiating these conferences. His practical ingenuity and his guidance in questioning the panel members has added a lot to the interest and instructiveness of these conferences. His detailed summaries at the end of each section provide valuable instruction for all physicians. I recommend this book as an asset for the busy practitioner and for hospital libraries.

N. A. ANTONIUS, M.D.

Peptic Ulcer: Diagnosis and Treatment. By Clifford J. Barborka, M.D. and E. Clinton Texter, M.D. Boston 1955. Little, Brown. Pp. 290. ($7.00)

The practitioner has here a useful manual on peptic ulcer. The authors, though internists themselves, are free from prejudice about surgery and present a fair evaluation of the indications for surgery. They stress—and properly so—the physician-patient relationship in treating the patient, not the ulcer. The often-neglected problem of postoperative management is carefully reviewed. Some may feel that for less than 265 text pages, a price of $7 is a bit high. However, the book is intensely practical—it even gives detailed recipes for upside-down cake, apricot flip and other foods used by ulcer victims. Medical treatment is emphasized. The anti-cholinergic drugs are discussed in terms of indications, contra-indications, dosage and expected results. Diagnostic methods are reviewed. Typical x-ray pictures are shown. Every reasonable technic now in ethical use for the treatment of peptic ulcer is described and evaluated. Included is an interesting explanation of the possible mechanism of ulcer formation and ulcer healing. The book is focussed on the professional needs of the general practitioner, but it won't do the internist any harm either. Altogether, a veritable Baedeker of the gastric and duodenal mucosa.

ULYSSES M. FRANK, M.D.

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Vol. XXIX January, 1956 No. 1

Tuberculosis—Fundamental Questions Still Unanswered

The following is from a monograph by E. M. Medlar, M.D., which was published as a supplement to the March, 1955, issue of THE AMERICAN REVIEW OF TUBERCULOSIS AND PULMONARY DISEASES. This monograph is a summary of Dr. Medlar's life-long study of the dynamics of tuberculous disease. For the practicing physician and the public health worker his conclusions are of such importance that with Dr. Medlar's permission they have been taken out of context to be presented to you. Those interested in the medical and pathological studies from which these conclusions are drawn are referred to the original work.

FLOYD FELDMAN, M.D., *Medical Director*
NATIONAL TUBERCULOSIS ASSOCIATION.

Therapy—Long observation has proved that bed rest, collapse of the lung and chemotherapy, wisely used, help to reduce the mortality rate and to restore the majority of tuberculous patients to a state of apparent health. Nevertheless, the pathologic evidence is overwhelming that the disease commonly remains in a suppressed unhealed state even in persons who present the picture of health.
Education—A better control of tuberculosis would be possible if the dynamics of the pathologic process were properly presented to medical students, who are the practicing physicians of tomorrow. In most instances, the first responsible person to have an opportunity to recognize a case of tuberculosis is the practicing physician. At this time the fate of many tuberculous patients is determined.

The teaching of the epidemiology of tuberculosis would be improved if basic information about the pathogenesis of the disease were included. It is interesting to show the decline in the mortality rate from tuberculosis during the past fifty years but this does not indicate the major hazard which revolves about the surviving tuberculous persons who harbor smoldering unhealed disease that only too often flares into activity. Not infrequently a tuberculous person who has had stationary pulmonary shadows for many years, if thoroughly investigated bacteriologically, will be found to be shedding tubercle bacilli. Persons with disease of this nature can be considered as chronic carriers. It is probable that they are the source from which a continuing annual crop of new patients acquire the disease. Too often they are not recognized.
Decline in Death Rate—It is of much greater importance to obtain accurate data on morbidity and relapse rates than to reiterate that the mortality from tuberculosis is declining. Deaths from tuberculosis now are most numerous among white males more than forty years of age. To explain this phenomenon, it has been proposed that these males are a vestige of the high incidence of tuberculous infection which existed thirty to forty years ago. Necropsies on persons more than forty years old who died from pulmonary tuberculosis can be separated into a group in which the lesions clearly indicate that a chronic disease of many years' duration was present, and one in which no such evidence was found. Progressive reinfection pulmonary tuberculosis is a reality and tuberculosis can be acquired at any age. There is no justification for complacency with regard to tuberculosis in this age group.

Tuberculin surveys have shown that only a small percentage of those who become reactors to tuberculin develop progressive pulmonary tuberculosis. Considerable time may elapse between the two events. From this it would seem that the incubation period, the lapse of time between the acquiring of the infection and the clinical manifestation, would be most unpredictable in tuberculosis. The emphasis upon chest roentgenograms for individuals and for entire communities has at times obscured the fact that a single roentgenographic survey of a community cannot predict the future problem of tuberculosis in the community, any more than a single chest roentgenogram of an individual can guarantee the future possibility of serious pulmonary tuberculosis in that person. These problems are related inherently to the dynamics of the disease.

Pulmonary tuberculosis is an endemic disease and, since it is air-borne, it can be considered as a herd disease. This endemic disease will persist, even if the mortality rate becomes negligible, unless some way is found to detect and to segregate these persons who have tuberculosis with an open cavity. Many such individuals are beyond middle age. The socio-economic problem that the disease creates is not generally appreciated. On the social side, the problem is one of wrecked lives and broken homes. The economic phase of the problem manifests itself in the inability of many tuberculous persons to compete successfully on a job with healthy persons; in restrictive policies of employers, and in public health laws which forbid a person with sputum positive for tubercle bacilli to work in several categories of employment. A consideration of the economic problems created by tuberculosis should cause no satisfaction with our progress in solving them.

BCG—A spectacular attempt to eradicate tuberculosis has been undertaken during the past decade by prophylactic vaccination with BCG. While such vaccination confers a degree of protection, this protection falls short of being completely effective. Prophylactic vaccination well may lessen the occurrence of the generalized disease which is more frequently encountered in a progressive primary infection than in a progressive reinfection. It is doubtful that any type of vaccination can eliminate the problem of pulmonary tuberculosis.

Chemotherapy—There have been some unwarranted and too optimistic assumptions relative to chemotherapy in tuberculosis and, a rash of ill-advised publicity. No one need question the beneficial effects of chemotherapy during its administration, and yet one may seriously question the long-range effect on the "curing" of the disease.

The publicity given to "miracle" drugs plus the developing tendency to treat patients at home and on ambulatory basis are greatly complicating the management of tuberculosis. Whether the present trend is wise remains to be proved. The problem of tuberculosis is by no means near solution. Relapses still occur subsequent to the withdrawal of chemotherapy. This fact should engender an attitude of caution.

Surgery—The reasons for favoring surgical resections of residual tuberculous disease are: evidence from necropsy studies is convincing that progressive tuberculosis is frequently not a generalized infection; that pulmonary lymph node tuberculosis in adults usually is an unimportant feature; and that often the pulmonary disease is limited to a relatively small area of lung tissue. Resection of the pulmonary disease offers, at this time, the best chance of eradicating the dangerous residual pathology. Chest surgery in tuberculosis should be given a thorough, intelligent, and fair trial. The place for surgery in tuberculosis will take considerable time to determine.

Unanswered Questions—What is the nature of the chemical process that induces necrosis? Why do some necrotic lesions undergo liquefaction and slough fairly promptly, while others do so after long delay and still others never do? Why, in many instances, do these bacilli fail to grow on culture media and to produce progressive disease in experimental animals? Why are some portions of the lung parenchyma more "vulnerable" than others? It will be necessary to obtain answers to at least some of these questions before one may talk about the eradication of tuberculosis.

The problem of tuberculosis is still immense and already has consumed large amounts of human energy and resources. If no more than a truce could be negotiated with this microscopic, parasitic, vegetable cell, eternal vigilance would be required lest the uneasy truce be broken.

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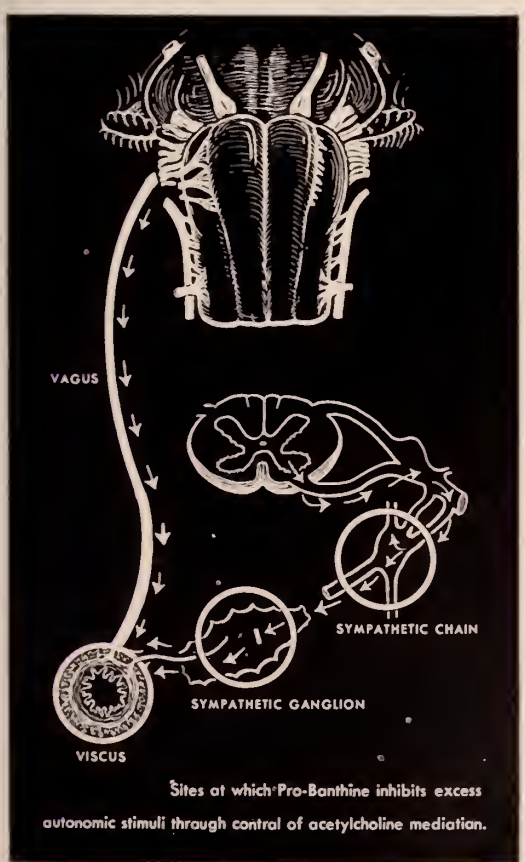
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1. Schwartz I. R.; Lehman, E.; Ostrove, R., and Seibel, J. M.: Gastroenterology *25*:416 (Nov.) 1953.

2. Roback, R. A., and Beal, J. M.: Gastroenterology *25*:24 (Sept.) 1953.

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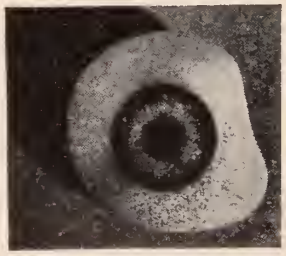
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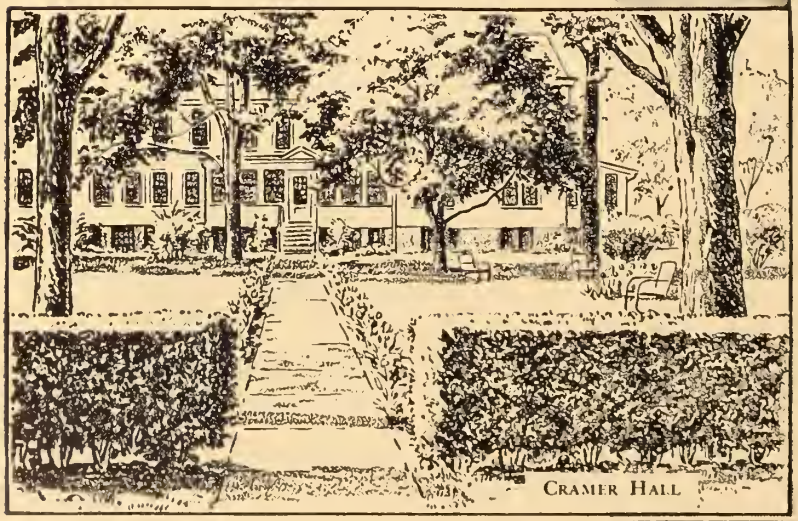
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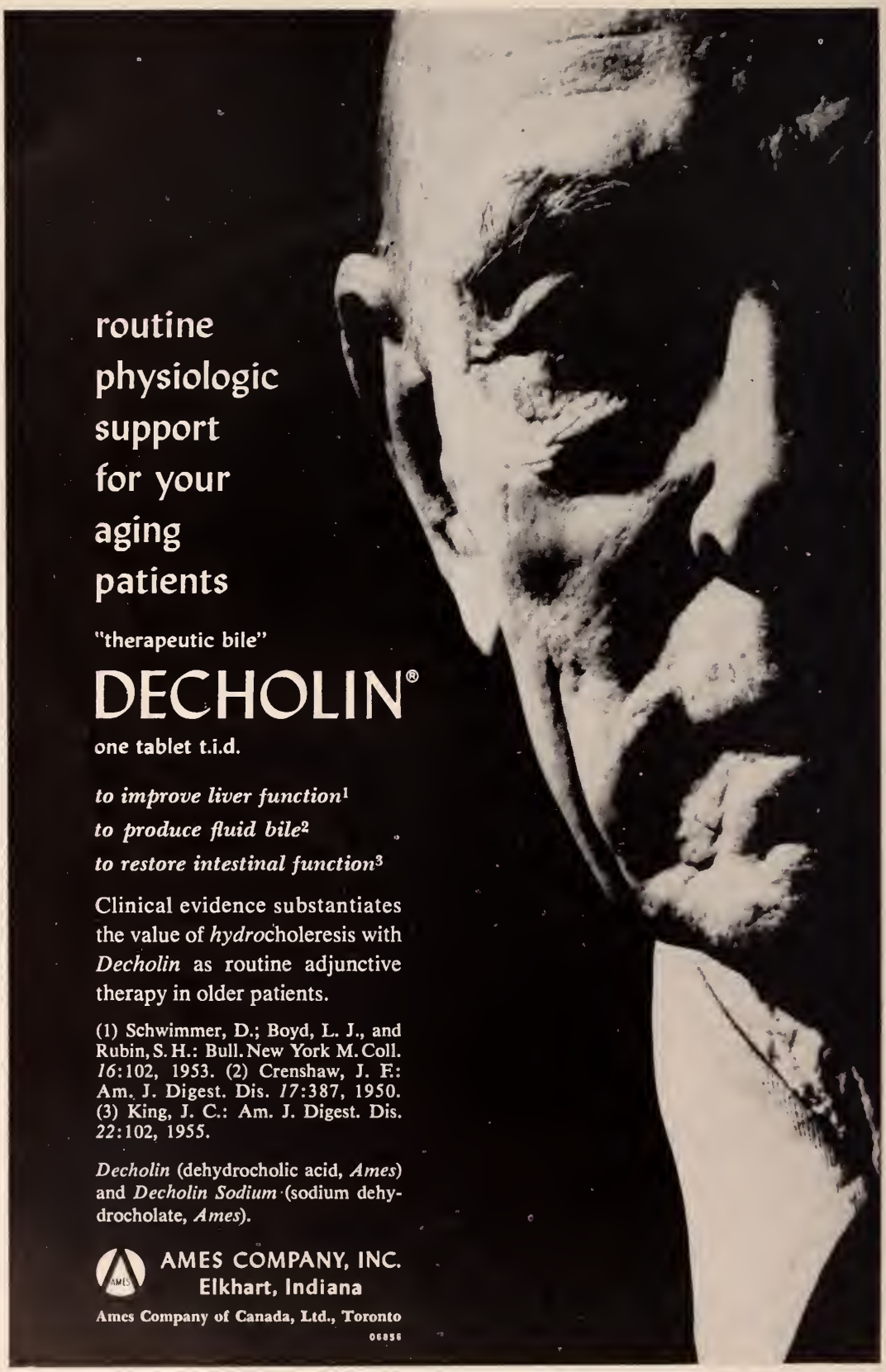
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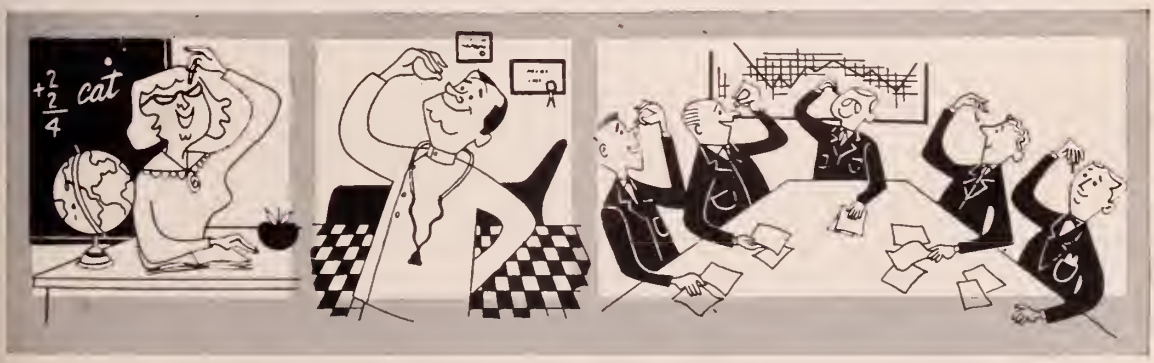
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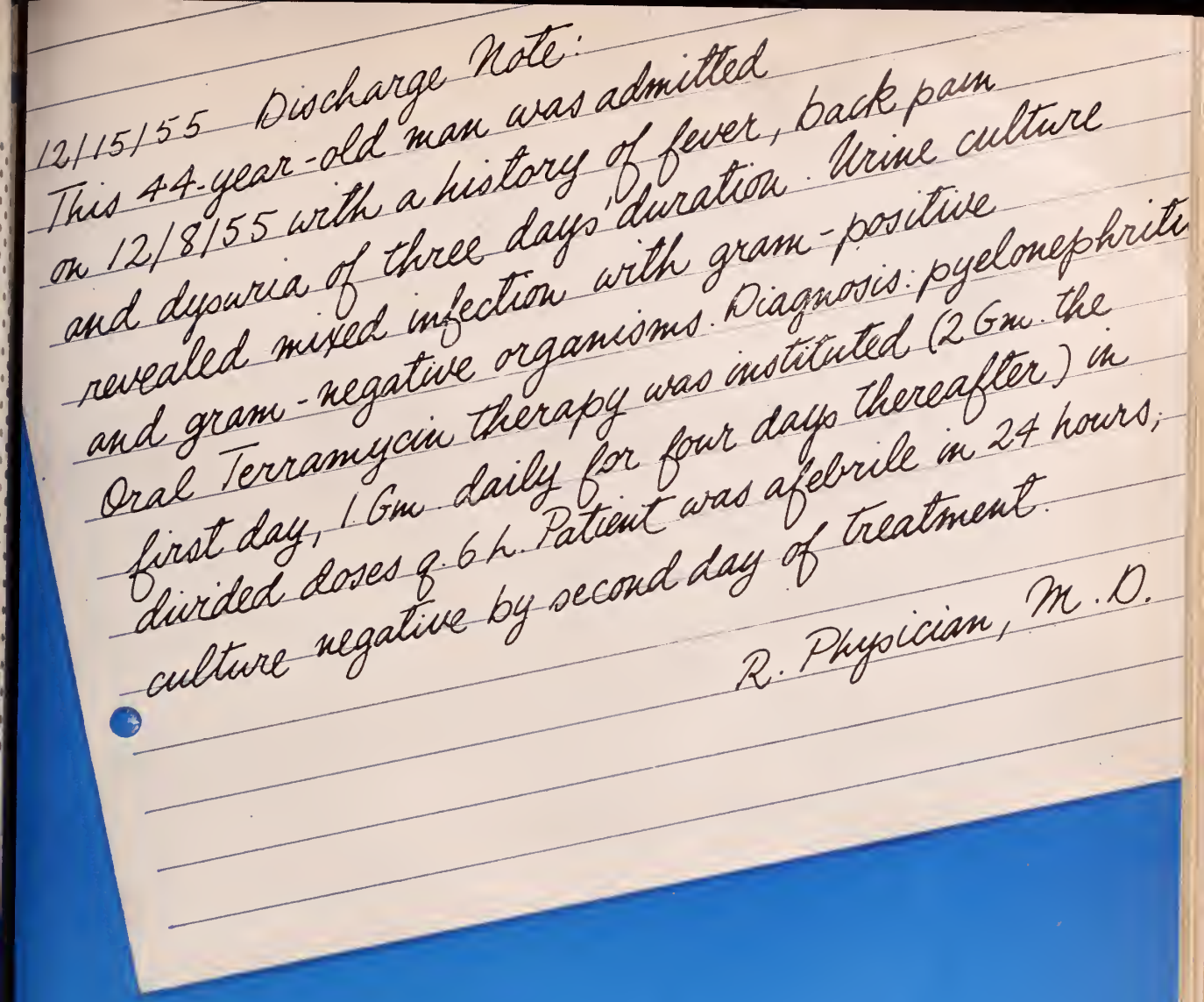
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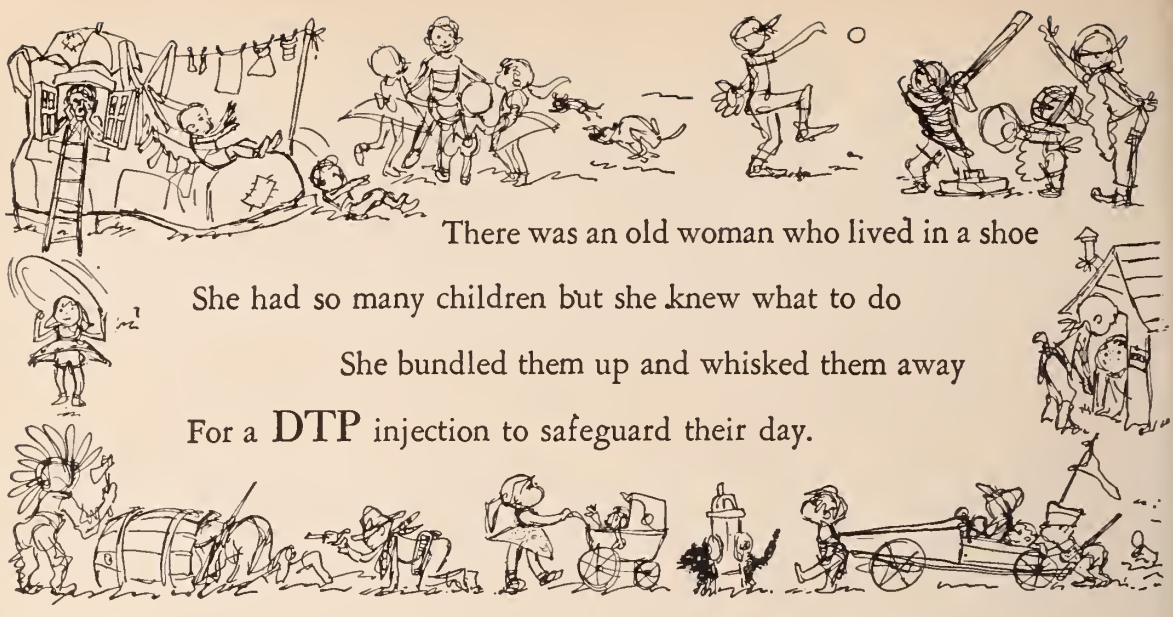
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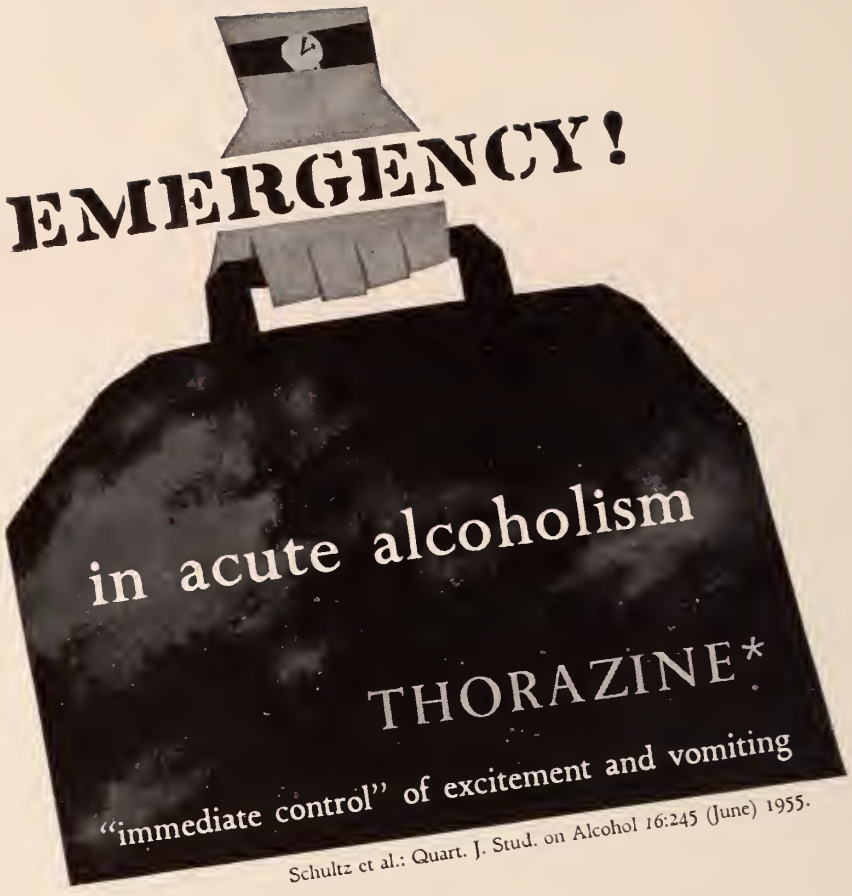
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1. Moyer, J.H., in discussion of Galen, W.P., and Duke, J.F.: Outpatient Treatment of Hypertension with Hexamethonium and Hydralazine. South. M.J. *47*:858 (Sept.) 1954.

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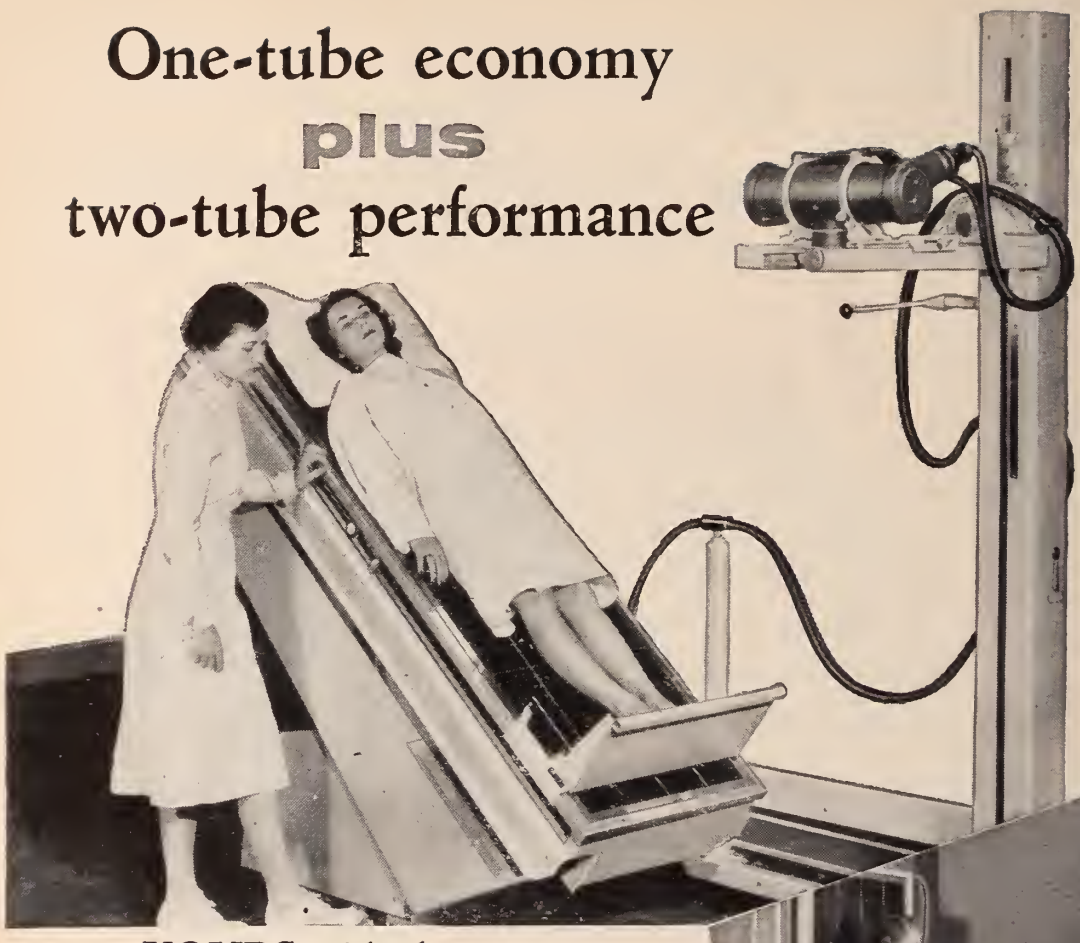
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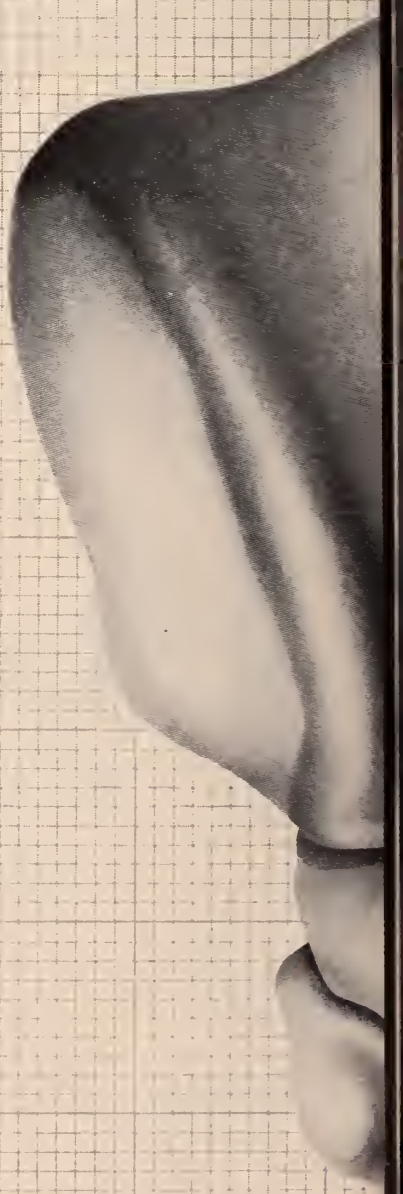
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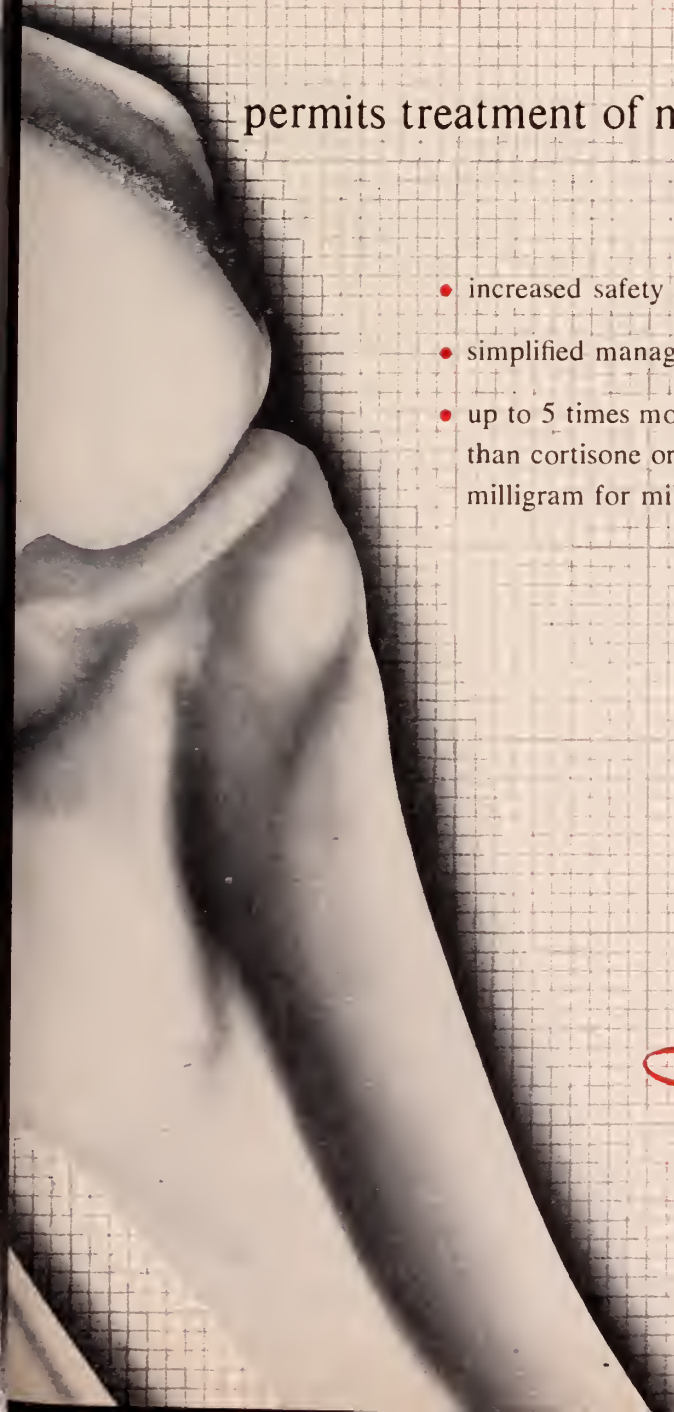
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REFERENCE: 1. Silcox, L. E., *A.M.A. Arch. Otolaryng.* 60:431, Oct. 1954.

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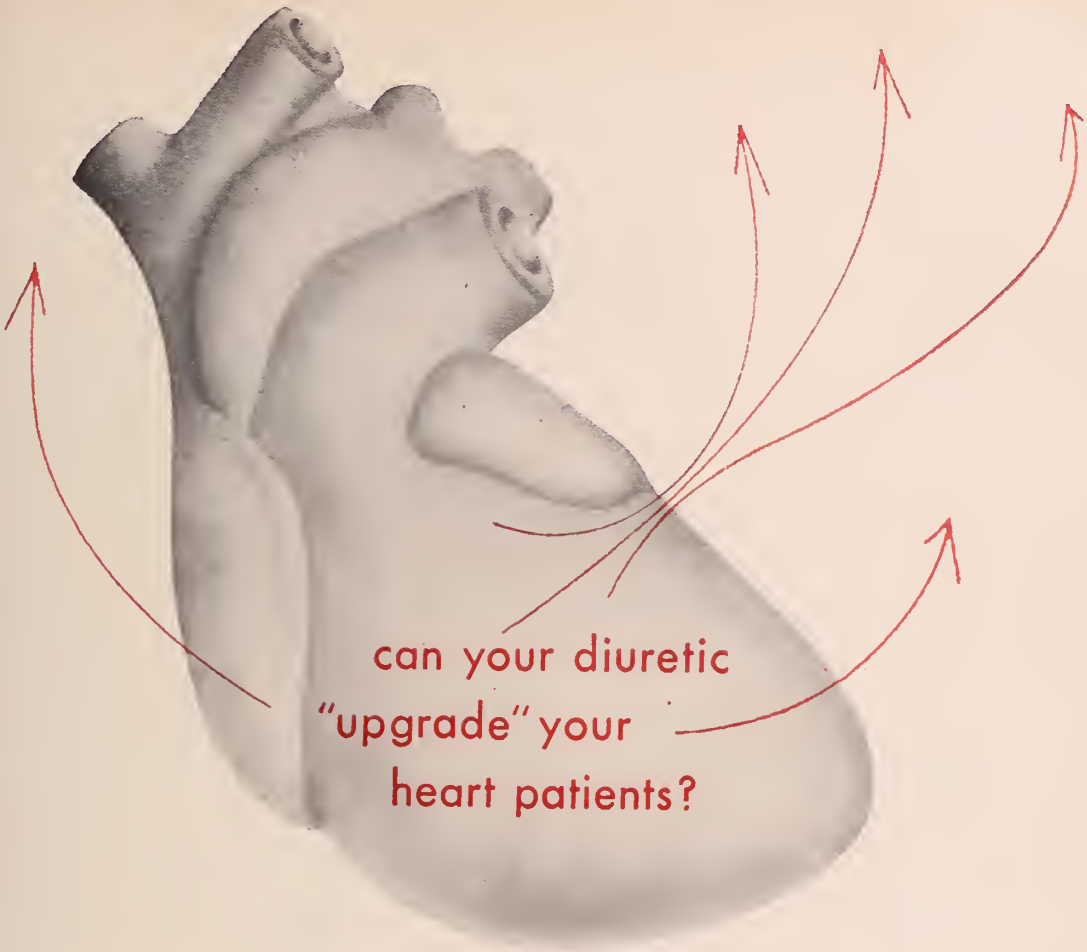
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1. McLester and Darby: "Nutrition and Diet in Health and Disease," ed. 6, Saunders, p. 195. 2. McCay, C. M., in Lansing: "Problems of Aging," ed. 3, Williams and Wilkins, 1952, p. 193. 3. Sebrell and Hundley, in Stieglitz: "Geriatric Medicine," ed 3, Lippincott, 1954, p. 189.

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On 6/13 penicillin was discontinued and erythromycin started in dosage of 200 mgm. q.i.d. By 6/17 the discharge had stopped and wound was completely healed by 6/19. Erythromycin was continued until the patient was discharged from hospital on 6/21. Temp. was normal throughout hospital stay.

Final diagnosis: breast abscess due to Staph. aureus.

Result: rapid and complete recovery on erythromycin following failure of penicillin.

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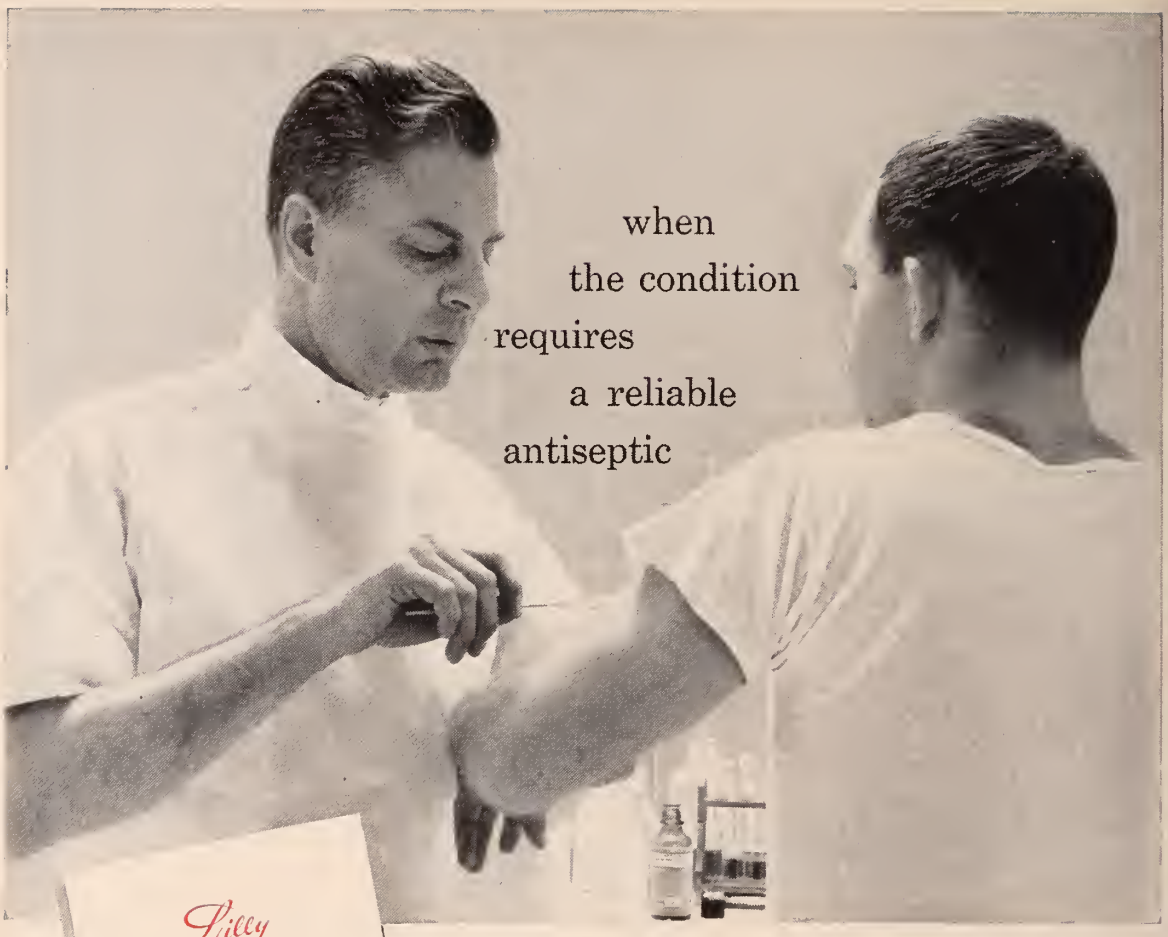
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Editorials • • •

Frederic J. Quigley, 1883-1955

The 148th President of The Medical Society of New Jersey was Dr. Frederic J. Quigley. He piloted our Society in the critical 1933-4 period. It was the time when the depression hit bottom, when the New Deal began, when a crescendo had been reached in demands for socializing medicine. Dr. Quigley died in 1955—the night before Christmas Eve.

Born in Coxsackie, New York in 1883, Dr. Quigley was graduated from the University of Louisville Medical School in 1906. After interning at St. Joseph's Hospital in Paterson, he entered general practice in Union, New Jersey. His interests always embraced civic and organizational activities as well as professional ones. As early as 1914 he was a member of the board of managers of the Hudson County Tuberculosis Hospital (now the B. S. Pollak Hospital for Chest Diseases), and for 19 years he was President of that Board. Eventually he became medical director of the hospital, serving in that capacity from 1949 until his retirement in 1951.

He joined the Hudson County Medical Society in 1913 and from the beginning took an active part in its affairs. The senior officers soon recognized in Fred Quigley a man who was willing and able to toil long on behalf of organized medicine. He rose through the ranks in his county, and became president of the Hudson County Medical Society in 1920.

Dr. Quigley had a rare gift for expression. As early as 1924 this was recognized by The Medical Society of New Jersey, when he was named an Associate Editor of this JOURNAL. In 1931 he joined the high command of our Society, being elected that year as a Trustee. He served our Board of Trustees from 1931 to 1939 and had one two-year term as Chairman of that Board.

Dr. Quigley was elected Second Vice-President of our Society in 1930, First Vice-President in 1931, and President-Elect in 1932. On retiring from the presidency, however, he did not rest on his laurels but continued to look for more tasks. The Society found them for

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him. After serving on the Board of Trustees he became Executive Secretary to our subcommittee on legislation—from 1939 to 1945.

During his service to the subcommittee on legislation he built an enviable record of goodwill in his relations with the legislators and of alertness with respect to legislation.

In his private professional practice, Dr. Quigley was recognized as a surgeon who combined careful surgical judgment with superior surgical craftsmanship.

In 1913, Dr. Quigley, then only 30 years old, spearheaded the formation of the North Hudson Physicians' Society and became its first president. Soon thereafter, he left his rapidly growing practice to serve in the Army, entering as a first lieutenant in the medical corps, to be demobilized two years later as a lieutenant colonel.

His periods of top service—the early 1930s as a presidential officer and the early 1940s as our legislative spokesman—were both eras of storm and stress for organized medicine. We needed firm hands at the helm then, and we found them in Frederic J. Quigley.

Psychiatric Services in General Hospitals

It could happen to you . . . a mother, sister, or other loved one, plunges into a deep depression. She must be restrained, chemically or mechanically, or she will commit suicide. She needs vigorous treatment—by psychotherapy, medication or electronic methods. And within two or three months she will be well. Where can you send her? A private institution must charge from $150 to $400 a week, for with its high staff-patient ratio and high operating costs it can do no less. Can you afford this for, say, 12 weeks? You shrink from commitment to a public mental hospital because the expected hospital stay seems so short for so cumbersome a method of admission, legal adjudication and transportation. Can you turn to a *general* hospital for the care of your relative?

In some cities in New Jersey you can. Here, with helpful, if limited Blue Cross coverage, you may place your patient. There is no long ride from home, no stigma, no legal commitment, and no placement in the overpopulated understaffed wards of our public hospitals—wards where gallant and overworked doctors struggle to take care of some 150 to 300 patients each. Yes, in some communities, you can utilize psychiatric services in a general hospital.

But in most parts of this state, you will find no such facilities. Although the institution calls itself a "general" hospital, the adjective is misleading. No hospital can give "general" service if it arbitrarily excludes the largest single bed-occupying disease grouping in the country (emotional and mental disorders).

It is interesting to speculate about the "reasons" advanced for this discrimination against psychiatric patients. Some hospital Boards say that to accept psychiatric patients is to invite legal complications, suicides, assaults and a "bad name" for the hospital. Yet several hospitals in this state have set up psychiatric treatment services (not scattered strong-rooms for custody) and nothing terrible has happened. Quite the contrary, the psychiatric wing, constantly filled, has augmented hospital income. The training of interns, nurses, attendants and residents has been advanced. Research possibilities have widened. The surgical and medical staff doctors have had a chance to see modern psychiatry in action. Patients and their families have been grateful for this provision of home-town short-term care. And a desperate community need has been filled.

Elsewhere in this issue,* we publish a brief but eloquent plea by Dr. Vinciguerra for the expansion of psychiatric facilities in general hospitals. Sooner or later, every community

* Page 63.

will insist that one of its general hospitals make provisions for the inpatient care of psychotics, psychosomatic problems and bed-ridden neurotics. And so for each multi-hospitalled community the question now arises: which hospital Board will have the imagination, the concern for public interest and the initiative to establish a psychiatric treatment section?

The Clinic Invades the Living Room

The television screen is more sensitive to possible obscenities than is the stage or even the moving pictures. The reason is obvious. You can keep your children from the movies or from the theatre. But you cannot keep them from the living room. (Sometimes, in fact, it is even called a "television room" as if television has become a synonym for living). In a way, television has a captive audience. To be sure there is always the greatest TV gimmick ever invented: the knob for turning it off. But if the TV drama morbidly magnetizes an immature auditor, the viewer is *not* going to turn it off.

There are numerous organizations — religious, civic, judicial and educational—interested in protecting the living room against obscenities on the TV screen. No one, however, seems concerned with the invasion of the living room by medical details which produce a fascinated disgust, a gruesomely sadistic reaction or an acute hypochondriasis, according to the auditor's temperament. It used to be said, half in jest, that the medical student would think he had each disease he studied. It can certainly be said, not at all in jest, that a less sophisticated audience than a group of medical students is going to identify with the patient in the TV drama. Since script writers prefer the rarer and less pleasant diseases, the viewers are now getting frightened by a choice battery of obscure but deadly illnesses. When delivering a baby becomes a TV spectacle, the more naive pregnant woman begins to worry about possible complications of labor. When bleeding is portrayed as a sign of hemophilia, every viewer is frightened by a cut finger. While this manufacturing of hypochondriacs may keep us doctors busy, it isn't really good hygiene—physical or mental.

There are some other angles too. For one thing, many people are—believe it or not—revolted at seeing such things as a pulsating human heart, a fresh placenta, or an avulsed tongue. Yet the arm is frozen in fascinated paralysis when it comes to turning off that knob. Also, the hammed up air of drama which pervades TV hospitals is unfortunate. When a patient actually enters a hospital, he is vastly disappointed because it does not conform to the script writer's picture of it. And similarly when his private family doctor fails to measure up to Dr. Kildare, there is disillusion.

To be sure the public has a right to know about medicine. The healthy way to do this would be to dispense that knowledge as the occasion arises, balancing it in proportion to the frequency or importance of the specific subject. Knowledge can be dispensed with balance, restraint, and accuracy so that it does not mislead, does not pander to morbid tastes and does not make hypochondriacs out of the hearers. There is no need for us to lead into the living room a parade of amputation stumps, trephined skulls or bleeding ulcers.

HAROLD GORENBERG, M.D.
Jersey City

Rheumatic Heart Disease in Pregnancy*

Practically every pregnancy in a patient with rheumatic heart disease can be brought to successful termination. If an abortion would benefit the patient it means she has been seen early enough to receive good medical care.

HEART disease is the number one cause of death in a number of American obstetric hospitals. This has come about because of the reduction in maternal mortality due to infection, hemorrhage and toxemia. Thus, heart disease is now the prime obstetric problem.

A diagnosis of heart disease should always be made with caution. No one should be so labelled unless the evidence is conclusive. In pregnancy we should be even more circumspect for many features of normal pregnancy mimic cardiac disease, particularly mitral disease. First, there are suggestive symptoms. Dyspnea is common in the latter months of pregnancy. Many normal women say they are more comfortable when sleeping on 2 or 3 pillows. Thus orthopnea is suggested. A trace or more of ankle edema in the evening is almost a constant finding in late pregnancy. Mild tachycardia is normal. Clinically there is a distinct impression of cardiac enlargement as a result of the transverse position assumed by the heart as the diaphragm becomes higher. There are some who believe that the heart actually does enlarge during pregnancy. Increasing the confusion there is the ever-troublesome systolic murmur. *A systolic murmur may be found in every pregnant woman if she is examined often enough.* With the exception of a long harsh systolic murmur over the aortic area, systolic murmurs are disregarded in our clinic unless occurring as one of a group of findings indicative of organic heart disease. Finally, the x-ray may complete the masquerade. A healthy heart may display the mitral configuration during pregnancy. I have seen the barium-filled esophagus displaced backward by the left auricle in the right anterior oblique projection, only to have the normal contour return in the postpartum period. Again, the high level of the diaphragm in late pregnancy must be evaluated carefully and the resultant transverse cardiac position appreciated before x-ray evidence of cardiac enlargement is accepted as real. For the same reason, increased haziness of the lung bases may appear, and too often this has led to a "retrograde" diagnosis of cardiac abnormality. This combination of signs, symptoms, and x-ray findings can prove most deceptive. There should be, therefore, a great deal of hesitancy in diagnosing rheumatic heart disease unless the auscultatory signs are definite and conclusive.

The criteria used in different clinics vary greatly. In Hamilton's series [1] about 6 per cent

*Read before the General Session on Obstetrics and Gynecology, 189th Annual Meeting of The Medical Society of New Jersey, April 18, 1955.

1. Hamilton, B. E. and Thomson, K. J.: The Heart in Pregnancy and the Childbearing Age, Little, Brown and Co., Boston, 1941

of the patients had mitral insufficiency as the only valvular lesion; *i.e.* a systolic murmur only. In Mendelson's series,[2] the figure was 7 per cent; in Drury's series,[3] 5.7 per cent; in our group it is just under 4 per cent. However Bunim[4] recorded mitral insufficiency as the sole valvular lesion in 22 per cent of his cases and Tillman[5] has reported it in 15. Possibly those who report a high rate of mitral insufficiency as the only lesion are including patients who should be classified as having "potential" or "possible" heart disease, or as patients who have no definitely proved organic impairment. Obviously statistical analyses of such series cannot be compared with more strictly selected groups. In our hospital *there has not been a single case of heart failure in a patient with mitral insufficiency alone.* The failure rate in any series including a large proportion of cases with mitral insufficiency as the sole lesion will be "diluted" by the inclusion of these patients who are in no danger of failure, and who, in the minds of some, have no organic heart disease.

ALSO pertinent to this problem of diagnosis is the report of Haig and Gilchrist[6] who followed up 352 women at dates varying from 1 to 10 years after their last attendance at the Cardiac Antenatal Clinic of the Royal Maternity Hospital. They found that 11 per cent had no detectable organic lesion. "One woman in ten, when reexamined some years after the pregnancy in which their heart had been suspect had in fact no organic heart lesion." Fifty per cent of these patients had been falsely diagnosed because of the presence of a mitral systolic murmur. In our own follow-up study we found a 13 per cent error. Considering the organizational differences in these two widely separated clinics, we believe this close agreement lends a ring of truth and points up the need for extreme care in making a diagnosis of heart disease in pregnancy.

Once the diagnosis of rheumatic heart disease has been made in the pregnant woman, what is the prognosis? The physiologic burden placed upon the heart by pregnancy has been well documented by Hamilton and his co-workers.[1] The cardiac load starts to increase soon after pregnancy begins and it progresses steadily until the 7th or 8th month; thereafter, for about 4 to 8 weeks, the blood volume, cardiac output, and velocity of blood flow decrease with a consequent diminution of cardiac work. This extra load is sufficient to embarrass a previously damaged heart unless other factors known to strain the cardiac capacity are appreciated and minimized.

In a search for factors of prognostic value in the management of the pregnant cardiac, Gorenberg and McGeary[7] analyzed the 345 pregnancies in rheumatic cardiacs seen at the Margaret Hague Maternity Hospital between 1933 and 1939. In this group, we had 77 cases of heart failure, an incidence of 22 per cent. This high incidence led us to formulate Rule 1: extra bedrest. All cardiacs in our clinic are urged to spend one to two hours in bed every afternoon and to get as much more than eight hours in bed every night as possible. Remembering the progressive rise in cardiac work in the later months, other restrictions in exertion and housework, are ordered in the 6th, 7th and 8th months.

In this review, I was immediately impressed with the effect of age on the incidence of heart failure. I divided the series into 5-year age groupings ranging from under 20 to over 40 years. There was a steady increase in the incidence of cardiac decompensation as we went up the age scale. In general the older the cardiac patient, the greater the possibility of a cardiac breakdown in the pregnant state. To make the association between age and inci-

2. Mendelson, C. L.: The Management of Delivery in Pregnancy Complicated by Serious Rheumatic Heart Disease, Am. J. Obst. & Gynec. 48:329 (1944)

3. Drury, M. I., O'Driscoll, M. K., Hanratty, T. D. and Barry, A. P.: Rheumatic Heart Disease Complicating Pregnancy, Brit. Med. J. 1:70 (1954)

4. Bunim, J. J. and Appel, S. B.: A Principle for Determining the Prognosis of Pregnancy in Rheumatic Heart Disease, J.A.M.A. 142:90 (1950)

5. Tillman, A. J. B.: Personal communication.

6. Haig, D. C. and Gilchrist, A. R.: Heart Disease Complicated by Pregnancy, Tr. Edinburgh Obst. Soc. in Edinburgh Med. J. 101:55 (1949)

7. Gorenberg, H. and McGeary, J.: Rheumatic Heart Disease in Pregnancy, Am. J. Obst. & Gynec. 41:44 (1941)

dence of decompensation more striking the patients were divided into 2 groups; those less than 25 and those more than 25 years old. The failure rate in the younger group was 10 per cent, compared to 34 per cent in the older group. From this finding came Rule 2: the cardiac who is more than 25 years of age is observed at weekly intervals.

The relationship between the incidence of cardiac failure during pregnancy and the functional capacity in the prepregnant state was determined. We used the American Heart classification as follows:

Class 1. Patients with cardiac disease and no limitation of physical activity.

Class 2. Patients with cardiac disease and slight limitation of physical activity.

Class 3. Patients with cardiac disease and marked limitation of physical activity.

Class 4. Patients with cardiac disease who are unable to carry on any physical activity without discomfort.

We have used in our determination of functional class the period *preceding* the pregnancy being studied. So determined, our group of Class 1 cardiacs showed a 3 per cent incidence of heart failure during pregnancy; the Class 2 patients 8 per cent; the Class 3 patients 73 per cent; and the five Class 4 cases, of course, 100 per cent. Thus the incidence of failure in pregnancy naturally increases as the functional capacity in the non-pregnant state decreases. The burden of pregnancy can be borne without serious difficulty by the comparatively well functioning hearts, while the same burden will cause decompensation in the badly incapacitated group. From this came Rule 3: all patients whose measure of functional capacity prior to pregnancy places them in Class 3 or 4 are hospitalized at their first visit to the clinic regardless of how they may seem to be at the time. They are kept at absolute bed rest for the remainder of the pregnancy.

Did the patient ever decompensate before? What a pathologic heart will do when forced to support a pregnancy may to some extent be foretold by its previous record. In our series there were 44 women who suffered broken compensation previously. Of these 33 (75 per cent) failed again when pregnancy complicated the heart disease. If a patient has never decompensated before, her chances of cardiac failure when the burden of pregnancy is assumed is 14 per cent. From this experience came Rule 4: all patients who give a history of previous decompensation are hospitalized when first seen and kept at absolute bedrest for the remainder of the pregnancy.

In analyzing the 77 failures that occurred in this series, I was forcefully impressed with the danger signals that the patients gave weeks in advance of serious trouble. These went unheeded time and time again. Too often was a cough disregarded, or looked upon as a symptom of an upper respiratory infection. Leg edema "passed off" as normal for the stage of pregnancy. Nose bleed was said to result from sinusitis. Too often was increasing dyspnea noted on weekly visits, written on the chart, but its significance overlooked. And far too often did these signs and symptoms progress for weeks and even months, finally confronting the surprised observer with a frank, far advanced state of heart failure. To prevent decompensation the slightest decrease in cardiac reserve must be searched for diligently and recognized. Symptoms and signs which may indicate a change in cardiac status should be considered as such and strict management instituted until they are proved to be extracardiac in origin. From the desire to prevent this type of error came Rule 5: At the first sign of any decrease in cardiac reserve, the patient is hospitalized and placed at absolute bedrest for the remainder of her pregnancy.

In the clinic we say that we do not see colds, bronchitis or sinusitis in our cardiacs. These patients are hospitalized as showing evidence of decompensation. The basic assumption is that nothing can happen to a pregnant cardiac except heart failure. However, if observation at bed rest and certain tests (vital capacity, venous pressure, circulation times) indicate that this is in error, the woman is returned to an outpatient status.

The group of 345 cases afforded an opportunity to assess the relative value of cesarean section as compared to vaginal delivery. I

know of no satisfactory quantitative estimation of the amount of work done during labor and the possible resultant strain on the heart. I know of no good way to estimate the burden placed on a heart by cesarean section and the postoperative period. However, I made an attempt to judge the effects of a normal spontaneous delivery as against the effects of a cesarean section by comparing the convalescent periods. The postpartum period in women who have had a cesarean section is accompanied by elevated temperature and pulse readings much more often than in patients who have had a vaginal delivery. Fever was present for more than five days in 21 per cent of the cesarean section group as compared to 2.6 per cent in the vaginal delivery patients. The pulse rate was over 90 for more than five days in 75 per cent of the cesarean section patients as compared to 19 per cent in the vaginal delivery group. The possibility of vomiting, abdominal distention, and pain with their concomitant strain upon the heart must also be carefully appraised in judging the burden to a patient of a cesarean section. And finally, of those delivered by an abdominal operative route, 14 per cent died. Of those delivered vaginally, only 2 per cent died. The odds are better than 6 to 1 for delivery per vaginam. It cannot be argued that this difference is due to a selection of the more serious grades of heart disease for section. As a matter of fact the analysis shows the opposite to be true. It was of interest to find that our most serious cardiac patients, that is, the group of Class 4 cardiacs, were all delivered by the vaginal route. They were considered too serious cardiac risks to be offered the "benefits" of cesarean section. From this experience (an increased morbidity and mortality rate following cesarean section with the added fact that the onset of cardiac failure during labor is a rarity) came Rule 6: surgical intervention is contraindicated. Labor is allowed to occur spontaneously. Cesarean section is made only when obstetric indications exist. (In the most recent analysis done at the hospital the cesarean section incidence in clinic cardiacs is 1.3 per cent, almost 99 per cent being delivered vaginally; whereas the overall hospital rate for section is about 4 per cent.)

Since 1939, our Cardiac Clinic has been conducted on the foregoing basic principles. From 1939 to 1942 a second group of 157 consecutive cases were managed through the Clinic. In this group our failure rate was 2½ per cent, as compared with the 22 per cent in the original series. The death rate was 0.64 per cent (one case) as compared with 3½ per cent in the original series. Several of the decompensations and the single death occurred in the first year of our experience when the rules were not as strictly defined as we now state. From 1946 to date we observed over 500 additional pregnancies in clinic patients with rheumatic heart disease, and we are able to report a single failure and a single death. This makes a series of more than 650 consecutive clinic patients with a total of only two deaths. No therapeutic abortions were performed. This total includes every pregnant woman with rheumatic heart disease who registered in the outpatient department at any time prior to delivery or prior to cardiac failure. The death rate in private patients is close to 10 per cent and in non-registered patients close to 20 per cent. This difference points up the necessity for close observation and rigid adherence to the rules.

The risk of death in any given year is greater for a woman with rheumatic heart disease, pregnant or not, than it is for a woman with a healthy heart. Obviously we cannot be expected to reduce the maternal mortality of cardiac patients to the low level prevailing for all other women. But we can compare the risk of death in the pregnant cardiac with that in the non-pregnant cardiac. Six hundred and fifty pregnancies represent about 585 patient-years of exposure to the risk of death; two deaths in this series would give an annual death rate of about 4 per thousand. The annual death rate of rheumatic cardiac women generally, in the childbearing age, is about 26 per thousand, which is six times the annual death rate in our pregnant clinic cardiacs. In other words, it would seem that pregnancy had reduced the risk of death. Is pregnancy good for heart disease? Or is it because pregnancy brought these patients under a doctor's care during the period of gestation?

What then of the prognosis of the woman who complicates her rheumatic heart disease by becoming pregnant? With certain rigid standards of management, the immediate prognosis is excellent. Since the great majority of deaths in pregnant cardiac women results from decompensation, it is axiomatic that to decrease the mortality rate one must strive to decrease the failure rate. Meticulous care does reduce the failure rate and has reduced the mortality rate. By anticipating heart failure we can prevent it. With meticulous care, with early and adequate treatment when indicated, the burden of pregnancy can be borne even by women with severe grades of cardiac damage; in short, the burden of pregnancy itself is not to be feared.

CONCLUSIONS

1. In pregnant cardiacs, abortion is unnecessary and cesarean section is not indicated.

2. Competent management reduces the inroads made upon the cardiac reserve during pregnancy to the point where decompensation and death are rarities. Practically every pregnancy encountered in a patient with rheumatic heart disease can be brought to a successful termination.

3. If a patient with rheumatic heart disease is seen early enough in pregnancy to be "benefitted" by a therapeutic abortion, she has been seen early enough to receive good medical care and thus be allowed to complete a successful pregnancy.

55 Bentley Avenue

Childhood Poisoning Control

The American Medical Association's Toxicology Committee* suggests four methods for combating the perennial problem of accidental childhood poisonings. These are: education, more stringent laws, establishment of poison centers, and greater efforts by local physicians.

Bernard E. Conley, secretary of the committee, said " . . . the curiosity of children coupled with the casualness with which many parents handle and store drugs and chemicals are predisposing factors to most unintentional poisonings." One alarming feature of the problem is the regularity with which household agents and drugs are swallowed by children. Leading causes are aspirin, barbiturates, petroleum products, lead, lye, and arsenic.

Of 14,000 accidental deaths that occur each year among children from 1 to 14 years, almost 1,500 are caused by accidental poisoning. This figure is "far from correct" for many cases are never recorded.

Apparent to everyone is the need for educating parents to the dangers of household agents. Manufacturers ought to consider the use of distinctive safety containers and better labeling with warning statements and when necessary uniformly standardized doses for drugs. Laws are far from adequate. Laws regulating the sale of household articles must be considered. Physicians and lay groups should work for state laws to strengthen federal ones.

The report* suggested that the sale of kerosene be restricted except in a special container, which would also carry a label warning of its poisonousness and inflammability.

Poison centers should be set up to distribute information on the type, frequency, treatment, and preventive measures for poisonings.

Another step would be the willingness of every physician to educate parents to the hazards of household agents. This could be done by pointing out corrective measures while making house calls, distributing safety literature to mothers, using bulletin board displays in the office, encouraging community programs to study the problem, and giving information to radio stations, newspapers, and magazines.

Much can be accomplished by asking pharmacists to put labels such as "Keep out of the hands of children" on all dangerous drugs.

*For the full report, see the Dec. 17, 1955, Journal of the American Medical Association. P. 1537.

Michael Vinciguerra, M.D.
Elizabeth

The Psychiatrist's Role in the General Hospital*

In this brief but eloquent discussion, Dr. Vinciguerra points out that no "general" hospital is worthy of that designation unless it provides facilities for inpatient psychiatric care. See the editorial section of this issue for further discussion.

It was the need to relieve human suffering which gave birth to the medical profession and later, to the hospital. Surely there is no human suffering as unhappy as that which plagues the person with emotional or mental disease. Any justification for establishing a general hospital will more than justify the creation of a psychiatric service within that hospital. The extent to which such a service can function depends on the hospital's basic policy and attitude, on its resources, on the willingness of the rest of the medical staff to cooperate and on the energy and resourcefulness of its psychiatrists. The pattern here is incredibly varied. Some general hospitals have well developed inpatient treatment services in psychiatry offering every therapeutic modality now available. Some have rooms for custodial care only. Some have nothing but a consultation service. Some hospitals, curiously, have good outpatient resources in psychiatry but do not knowingly accept any psychiatric inpatients.

Another reason for the amorphous state of general hospital psychiatry is failure to realize the actual and potential contributions which a psychiatric service can make to the hospital's well-being. This ignorance of psychiatry's potential is not limited to the Board and administrators. It is often shared by the medical staff and by the profession at large. This is because too many physicians used to divorce psychiatry from clinical medicine. Only recently has it dawned on many doctors that every physical disease has emotional effects and that emotional disorders cannot exist like disembodied ghosts, outside of an anatomical framework.

Occasionally a progressive hospital administrator finds it well worth while to retain the services of a psychiatric consultant. Most hospital administrators, however, have never bothered to weigh the advantages of having a psychiatric inpatient service. I will not spell out the advantages in detail, but consider in broad terms, the favorable effects of such a service on the economy of the hospital (it is a profitable service in dollars and cents), on the efficiency of the hospital (by identifying the neurotic it saves much unnecessary laboratory work), on the hospital's research potential, and on its function to train interns, residents, attendants and nurses.

At the medical profession there is frequently hurled the charge of "incomplete medical care." This grievance has, indeed, gained such momentum as to put us all on the defensive. And eventually this has had its effect. Two decades ago a plea like this would have fallen on deaf ears. Today, more and more progressive hospitals are establishing pyschiatric services. By

*Discussion before the Section on Neuropsychiatry, Annual Meeting of The Medical Society of New Jersey, April 19, 1955.

this time, the profession sees the need for recognizing that psychiatry is an integral part of medicine. Medical schools now give more time than ever before to teaching psychiatry, mental hygiene and personality structure. More and more, the wise general hospital administrator recognizes that a psychiatric service is not an ancillary superstructure in his hospital but an essential, indeed, a basic service. It serves the patient, the profession, the community and the general hospital itself. We talk much about treating the patient "as a whole"; about treating the person not the disease. But these can be nothing but fancy words unless we implement them. And organizing a psychiatric service in a general hospital is one method of implementation.

In this evolutionary period, we find that psychiatry can live comfortably with "Mother Medicine" and with the rest of her off-spring at the general hospital. This re-union was not brought about by family ties, nor by accident. After many years of scientific investigation, it was found that, in the tree of medical knowledge, the function of one of its branches was detoured, producing spurious off-spring. Loose connections were found at the point where the functions of clinical medicine and psychiatry met. To bridge the gap thus formed, it was necessary to enlist the assistance of the psychiatrist.

This mission of restoration imposes on the psychiatrist more than his best efforts; for on him rests the prime responsibility of helping restore the greater part of the missing link to the practice of medicine. The alloy, which restores and binds the missing link is the fusion of psychiatric knowledge with that of medicine and *vice versa*. To accelerate this fusion, effort should be directed toward the development of a psychosomatic service in every general hospital.

What will such a service do?

1. It will make the hospital more useful to the community by filling a desperate need.

2. It will help train the intern, the resident, and nurses in the understanding of people as well as diseases.

3. It will make it possible for the hospital to give an honest well-rounded service. No institution can be a *general* hospital if it rejects the body system which accounts for half of all illness—the emotions.

4. It will open the door to new and challenging research.

5. It will assist the hospital financially. These private beds in psychiatric wards and sections are hardly ever empty.

But a strong, active, therapeutically oriented psychiatric service will redound to the credit of the hospital, the service of the community, and the development of the physician.

604 Westminster Avenue

Visualizing Foreign Bodies

From the South African Medical Journal, (1955) comes a paper by Jan Heselson describing a precise method for the radiologic localization of radio-opaque foreign bodies. The part is fluoroscoped and the site of the skin incision is decided. A local anesthetic is infiltrated into the skin downward towards the foreign body. The needle is approximated to the foreign body by visualization on the screen. Then methylene blue solution is injected and the needle withdrawn. The dye marks the needle track and site of skin puncture. It is then possible to make a surgical incision for the removal of the foreign body at the precise point indicated. At surgery, steps should be taken to secure a bloodless field. Avoid the injection of too much dye or its diffusion in the tissues will defeat the purpose. This method is of particular value in locating minute foreign bodies and those deeply embedded. The dye is absorbed in a few days.

Louis J. Levinson, M.D.
Newark

Role of the Isotope Clinic in the Practice of Medicine*

Here is twentieth century medicine indeed: atomic medicine, radioisotope medicine. For the first time in its history this JOURNAL *now presents a practical clinical rundown on the role of radioisotopes.*

Within recent years new sources of radiation have become available to the radiologist. These include the radioactive isotopes now produced at the Atomic Energy Commission's laboratories and available in sufficient quantities for clinical use. The administration of radioactive isotopes at the Newark Beth Israel Hospital has been from the onset, under the supervision of the Radiology Department. In the typical general hospital, the radiologist, with his specialized training in the handling of radioactive material and knowledge of radiation physics, is in a key position to initiate a radioactive isotopes program.

The radioactive isotopes now used in clinical medicine fall into three main categories; (1) for internal administration, by ingestion or intravenous injection, (2) as a source of external Beta radiation, (3) as a source of external Gamma radiation, replacing conventional radium therapy or super-voltage x-ray therapy.

CLINICAL APPLICATIONS

At the Newark Beth Israel Hospital we used the radioactive isotopes iodine, strontium, gold, and phosphorus. During the first four years of its operation, 1214 patients were admitted to this clinic for diagnostic and therapeutic procedures involving the use of these radioactive elements. At present, radioactive iodine has the widest application; next in order of frequency are radioactive phosphorus, radioactive strontium and radioactive gold.

RADIOACTIVE IODINE

The process of selective localization of iodine by the thyroid gland was first studied by means of the tracer technic with radioiodine by Hertz in 1938. These findings were a confirmation of Marine's work in 1915, utilizing conventional bio-chemical methods of investigation. In 1938 Hamilton and Soley reported that the radioiodine uptake patterns were characteristic of the patient's thyroid status. Since then, many others have investigated the method and its application to clinical problems. There are various methods used in the evaluation of thyroid function with I-131†. The 24-hour uptake study is most frequently used. More refined technics are at times required to rule out borderline cases of hyper-

*Read on April 18, 1955 before the Radiology Section of The Medical Society of New Jersey.

†I-131 is radioactive iodine.

thyroidism, and to determine function in thyroid neoplasms.

The localization of radioiodine in aberrant thyroid tissue and in carcinoma of the thyroid gland metastases, can be studied by a directional Geiger or scintillation counter. If successfully designed, such a counter permits the demonstration of uptake of I-131 by a nodule, lobe of the thyroid gland or metastasis from carcinoma of the thyroid gland. As a rule the best differentiated malignant tumors, the follicular adeno-carcinomas of the thyroid gland show the greatest uptake of radioiodine. Metastatic lesions of the thyroid gland which at first showed no uptake, developed uptake of I-131 after extirpation of the thyroid gland.

Radio-autography is also of practical value in the study of thyroid function in malignant and non-malignant neoplasms. It confirms previous studies with the directional Geiger counter and gives a graphic record of the distribution of the I-131 within the tissue itself.

In the management of toxic diffuse goiter, I-131 has now become an accepted and successful method of treatment. We have now under observation in our clinic about 335 individuals who have been treated with radioactive iodine for hyperthyroidism. The only complication encountered was hypothyroidism in an occasional patient. This was readily controlled by small doses of dessicated thyroid extract. Euthyroid function usually was reestablished in these hypothyroid patients in from 6 to 12 months.

In selected cases of intractable angina pectoris and heart failure, massive doses of I-131 have been administered. This method of producing hypothyroidism was first advocated by Blumgart, and has been used by us in 38 patients. Some of these individuals have obtained dramatic and prolonged relief from 2 to 6 months after its administration.

Twenty-nine cases of carcinoma of the thyroid gland have been studied with tracer doses of radioiodine. Only six showed significant uptake in metastatic lesions. Of these, four were chosen for intensive therapy with radioiodine. Sufficient time has not elapsed to determine the long-term effects of this therapy on all of these patients.

RADIOACTIVE PHOSPHORUS

After the injection of radioactive phosphorus, the liver, spleen, kidney and bone contain the largest amounts of this substance. The result is a somewhat selective Beta ray irradiation of the bone marrow and other hematopoietic organs. Radioactive phosphorus is known as P-32. I have used it in a few selected cases of leukemia and most frequently in the treatment of polycythemia vera. At present P-32 is the treatment of choice in polycythemia vera. Prolonged remissions have been obtained with it in this disease.

STRONTIUM-90

Strontium-90 has a long half life of 20 years and is therefore used only in external applications. It disintegrates through the emission of Beta particles. Beta rays from this source have a penetrability of about 4 millimeters of tissue. It is therefore eminently suited to the irradiation of tissue near the surface, to the exclusion of the underlying layers. Friedell and his associates have reported no demonstrable difference in the biologic effectiveness of Beta rays from radon sources or strontium-90. Because of its long half life the strontium-90 source may be used for many years with only a yearly recalibration by the original manufacturer.

It has been used by our group in the treatment of small hemangiomas in infants, vascularization of the cornea, pterygia and superficial carcinoma of the sclera.

RADIOACTIVE GOLD

Radioactive gold has a half life of 2.7 days and emits both Beta and Gamma radiation. It is used chiefly in the control of ascites and pleural effusions caused by malignant neoplasms. How fluid formation is inhibited by colloidol radioactive gold is not clear. It is probably due to a nonspecific effect resulting from fibrosis of serous surfaces on which it is deposited. The preparation is familiarly known as AU-190.

The intracavity method of administering gold is performed by a simple infusion device similar to that used for the intravenous ad-

ministration of fluids. Between 200 and 400 milliliters of normal saline solution are used to rinse the radioactive gold into the cavity. The patient is then instructed to move frequently to aid free-mixing within the cavity. The most suitable patients for radioactive gold therapy are those without large neoplastic masses, in fair general health, and with no symptoms other than those related to the accumulating fluid in pleural or peritoneal cavities.

These patients receive 150 millicuries for ascites and 75 to 100 millicuries for pleural effusion. The concentration of gold in the cavity fluid decreases rapidly. Most of the early decrease in the first three or four days is attributed to simple adsorption of the colloid on the serous surfaces of the cavity.

SUMMARY

THE clinical applications of radioisotopes have now been developed to the point where most large and medium sized hospitals must consider at least a limited isotope program. The radiologist is in a unique position to direct this program and to be its coordinator. The scope of this program will depend on the size of the hospital and the interests of the staff. It will probably include thyroid function studies, blood volume determinations, radioactive phosphorus therapy of leukemia and polycythemia, radioactive gold therapy for effusions incident to generalized abdominal or pleural carcinomatosis, and radioactive iodine therapy for exophthalamic goiter.

201 Lyons Avenue

DISCUSSION

DR. FRANK BURSTEIN, Newark: The strontium applicator is a welcome addition to our therapeutic equipment. It should be used by radiologist and ophthalmologist working in conjunction. The dosage and areas of application are a common problem; we decide on a dosage to be used but there are individual variations and each patient must be treated on an individual basis. That can be determined as the case progresses.

Ordinarily, we treat the patient once a week. The procedure is as follows: The eye is anesthetized with two drops of ½ per cent tetracaine,† the lids are retracted and the applicator applied directly to the surface to be treated. We have an observer present with a stop watch so that our timing is accurate. We have never gone over one minute. We have no trouble with eye movement or unsteadiness in holding the applicator firmly to the treated surface.

The cornea and lens are sensitive to radiation. We avoid the area of Schlemm's canal so that we do not obliterate this excretory path of the eye and wind up with an intractable glaucoma. At a depth of 6 millimeters there is only a 1 per cent concentration of Beta Rays. The lens is 4 millimeters deep and there have been several cases of cataract formation following the use of the applicator. However, my hope is that if sufficient care is taken, this is avoidable.

The strontium applicator should be used in selected cases and does not supplant other accepted forms of treatment. Its greatest use is to obliterate vessels, especially in cases where the vascularization causes symptoms of irritation. I have so used it. I remember a young man who lost one eye after a severe chemical burn. The cornea of the other eye was badly scarred. Many vessels were present with signs of irritation. By obliterating the vessels we rid the man of his irritative symptoms and at the same time cleared his cornea so much that his vision was markedly improved. I have used it on neo-formation vessels following surgical removal of pterygia. These vessels disappear as if by magic. I used it on a carcinoma of the globe superficially placed and at my last examination, there was no trace of the tumor. The area was perfectly clean. Incidentally, we used 18,000 r.e.p. whereas with vascularization we employ as little as 2,000 r.e.p.

I would like to say something about the effect of radioactive iodine on exophthalmos in hyperthyroidism. I have seen only two cases in which radioactive iodine was given and I was impressed by the amount of recession of the exophthalmos. It would be interesting to study a large series of similar cases to see whether that is universally so.

Dr. Levinson stated that after the injection of P-32, large amounts of phosphorus were found in the liver, spleen, kidney and bone. It is now being used as an aid in the diagnosis of intra-ocular neoplasms. The eye does not lend itself to biopsy but P-32 will actually be in the nature of an eye biopsy. We plan to start using this material in the near future. The test starts by injecting 500 to 750 millicuries of P-32 intravenously. Then tallies are taken by a Geiger counter at the limbus of the normal eye in position 12, 3, 6, and 9 o'clock. Then the counter is placed as close to the lesion as possible in the diseased eye. These counts are recorded as the number per minute. Readings are taken after one hour and 24 hours. To be positive this test must show a concentration of 30 per cent or more greater than the average in the normal eye after

†The form of tetracaine used was the Winthrop-Stearns brand, tradenamed as Pontocaine®.

one hour and the 24 hours must show more than the 30 per cent.

It was soon shown that the concentration of P-32 in neoplastic and inflammatory tissue was greater than that in normal tissue. It then became necessary to find a means of differentiation. This appears to have been found when the 24-hour reading is higher than the original 30 per cent concentration found at the end of one hour. In serious retinal detachments, the test is negative.

This has one drawback. It is difficult to get the Geiger counter over or near a posterior lesion. However, at the Wills Eye Hospital, under Leopold, Eisenberg and Terner, work is being done with a special Geiger counter and this problem may soon be solved. If the patient has only one eye—or if both are diseased or if the tumor is in a phase of low metabolism this may lead to error. However, it has been judged that there is only a 5 per cent error in this test which is certainly a great advantage over previous practice where one took a 50-50 chance on the enucleation of an eye with a diagnosis of malignancy. I remember an old lady where I removed an eye which clinically had all the criteria of a malignancy. Histologic examination revealed a massive hemorrhage and no tumor.

Dr. Samuel J. Penchansky, Newark: Radioactive phosphorus has been used in the treatment of polycythemia since 1938 and has been used in the radioisotope clinic of the Beth Israel Hospital in Newark, N. J. since 1951. Our cases for P-32 therapy are carefully selected to meet the diagnostic criteria for polycythemia vera, the pancytosis of unknown etiology. They have presented clinically: headache, marked weakness, lassitude, and other symptoms relating to peripheral vascular disease such as claudication, parasthesias, thrombosis and hemorrhage. We eliminated all cases of secondary polycythemia or erythemia following chronic hypoxemia as noted in pulmonary diseases, acquired chronic or congenital diseases, vascular and endocrine disturbances, and erythemias which reflect hemoconcentrations. Dependence upon erythemia alone for the diagnosis of polycythemia vera is erroneous. This may lead to improper therapy. Our hematologic criteria include not only erythemia, leukocytosis, thrombocythemia and elevated hematocrit, but also a demonstrated increase in the total blood volume before the patient is referred for P-32 therapy.

The isotope department renders a major service in the determination of the blood volume and the treatment of polycythemia vera. The use of dyes for the accurate determination of blood volume has been superseded by methods utilizing radioactive isotopes particularly radioiodinated serum albumin. The method used in our isotope clinic is relatively simple and the material is available commercially under the trade name of Risa®, five microcuries of radioiodinated serum albumin that are injected intravenously for the test. This amount of radioactive iodine is considerably smaller than the amount of I-131 administered to a patient for an uptake study or treatment for thyroid disease. Where this minute amount of iodine may be contraindicated, there may be given concomitantly Lugol's solution which will block the radioactive iodine from entering the thyroid gland. The total blood volume is determined by an equation using the total radioactivity of the injected radioiodinated serum albumin in comparison with the radioactivity of heparinized blood. The amount of blood volume is expressed in cubic centimeters per kilogram body weight and the figures of 55 to 80 of whole blood per kilogram have been accepted as the normal ranges. We have been able to eliminate all doubtful cases in which secondary polycythemia or hemoconcentration played a major factor. Cases of hemoconcentration presenting a red cell count of over 6,000,000 have been demonstrated to have blood volumes within normal limits, and are not cases of true increased blood volume which must be present before consideration is given for therapy.

The patient accepted for P-32 therapy is given from four to six millicuries of P-32 in divided doses of two millicuries daily. The phosphorus is administered orally. All but the first dose is administered in the isotope department. The subsequent doses may be taken at home without the aid of a physician. We have found that this simple method compares most favorably with the one employed by clinics giving the isotope intravenously. There is a latent period of four weeks during which there is little or no drop in the red cell count after which there is a gradual decline in the red cell count until a maximum fall is observed in about twelve weeks. The level remains normal for a year or more in the average case. Patients may remain with a normal red cell count for as long as three years; possibly longer. The particular action of the P-32 is thought to be due to an inhibition of the mitosis of the polycythemic normoblasts at a more active rate than the normoblasts of the normal marrow. The platelet count shows a more dramatic and rapid fall and reaches its lowest level in usually four to six weeks with little or no latent period observed. Relief from the symptoms of polycythemia such as headache, fatigue, and parasthesias were noted early in the treatment of our cases and corresponded to the fall in the platelets and was not associated with any reduction in the red cell count. We have noticed that the complaints of the patients mirrored an appreciable increase in the number of circulating platelets. Where the thrombocythemia in the untreated patient was very high, over 1,000,000 platelets per cubic millimeter, and where the reduction of platelets was not maintained for at least four to six months a second and occasionally third course of P-32 of four millicuries has been administered. There are no adverse reactions to the P-32. I have not observed any untoward hematologic reactions in my series. I have used P-32 in chronic myelogenous leukemia and malignant lymphomas without any encouraging success However, the radioisotope clinic has been a valuable adjunct in the treatment of polycythemia vera.

Joseph R. Jehl, M.D.
Clifton

Non-Viral Factors in the Cause of Common Colds*

With all our thinking focused on "viruses" we forget non-viral factors in the common cold. Why are there no colds in fox-holes? What role is played by diet and by environment? Read on and find out . .

The virus etiology of colds is so generally accepted that it seems to be presumptive heresy to question it. But my curiosity is whetted by the inability of the bacteriologists and virologists to produce a virus. Even if one does develop a virus, the other specialists can never confirm his experiments. I do not deny the existence for virus; but I do think it is blamed too often and other causes are neglected.

In pediatric practice especially, one is impressed with the number of "colds" which afflict infants in the newborn period. They sniffle and snort, have great difficulty with feeding and are generally uncomfortable. Antibiotics, nose drops, sulfonamides, and aspirin are without noticeable effect. Did you ever see one of these "colds" clear up with a milk substitute? If you have not, I assure you the cure takes place in twenty-four hours. I mean a milk substitute, not a substitute milk. Too often I find the baby has been on a dozen different formulas and then I am told, he had evaporated milk, pasteurized milk, homogenized milk and powdered milk, made by six or eight different companies and he has not been any better on any of them. Try the soy bean preparation and see the results.

In many older children in whom there is a similar history, one usually finds large, boggy tonsils and hypertrophied adenoids which almost fill the pharynx. These children give a more definite history of tonsillitis and otitis media. It is gratifying to see how quickly this swollen tissue will become almost normal with restriction or avoidance of certain foods.

In other cases, the symptoms are not dependent entirely on food. These children give a history of six to eight "colds" every winter, which keep them home a large part of the school year. They are well from about mid-May to mid-October. About the time the heat is turned on the colds begin. Is this due to overheating and dehumidified air? Is it due to overgrowth of bacteria and viruses? Is it due to poor ventilation? Is it due to the repeated irritation of the tissues of the respiratory tract by the various animal hairs which are so prevalent in our homes?

These colds are not present all the time, just every few weeks. They run in a definite pattern. They coincide with holidays. The duration of the "colds" is similar to the duration of the holiday seasons. This may be due to increased activities in the home, or increased consumption of certain foods, or both. You know what children eat during the holiday periods. Changes in the home atmosphere due to cleaning, new clothing and bedding as well as certain foods are important factors. Don't

*Read April 18, 1955, Annual Meeting, The Medical Society of New Jersey.

forget the importance of cosmetics and tobacco smoke too; particularly cigarette smoke. These children are the ones who are particularly reactive to that stuff we call dust.

In a different age group and under vastly different conditions I was greatly impressed by the scarcity of colds in the fox-holes. During the winter of 1944-45, I had the opportunity to observe combat troops at first hand. There were no colds in the fox-holes, but only when the men were quartered in houses. Living with maximum discomfort, living in a hole in the ground, constantly cold, having insufficient sleep, constant anxiety, irregular or inadequate meals, and totally inadequate sanitary facilities, these men were healthy. Housed, they were happier but not healthier.

I HAVE cited several examples which may seem quite widely separated but I am emphasizing the widely separated causes of "colds."

Several substances are quite important. Milk and chocolate are at the top of the foodstuffs list. When I have the mother eliminate or restrict these foods I frequently find a cessation of symptoms. This is not always easy to accomplish. A boy of eight whom I saw some two years ago had complete relief as soon as he was put on a restricted diet and hyposensitization. He was well all spring and summer, but shortly after school started the family harassed me. The father gave me dirty looks, the mother tearful ones, and insistent Billy persisted in his story that he was not getting milk. But one of the playmates squealed. The boy was getting milk in school because he had appealed to the teacher's sympathies. We stopped the milk and he stopped coughing. His symptoms returned after six weeks. The answer: a substitute teacher who hated to waste the chocolate drink and gave it to him. So he got sick again. These are not the only foods which may produce symptoms because I see many exacerbations of all types of allergies from eggs, nuts, spices and onions. Spinach, beets, carrots are not on my most highly approved list either. Oranges which are so often indicted, actually cause very little trouble.

Foods are only a part of the picture. Inhalants are certainly as important and we have ever so many irritant materials about the house; feather pillows, down quilts, rug pads, fuzzy woolen blankets, upholstered furniture, fur clothes and toys. Animal pets also may cause trouble. The individual does not have to come in direct contact with these things. Just hanging these materials in an open closet has been sufficient to produce severe symptoms.

The relationship of the foods and inhalants to colds and fever may be puzzling. If, however, you think of this possible pathogenesis, it will be more easily understood. The acute catarrhal stage produces swollen, boggy tissues. These unhealthy cells are more easily invaded by the bacterial inhabitants of the nose and throat. Their growth produces more symptoms with fever and evidence of pus in the tonsils, ears and adenoids. This phase responds to the antibiotics and the results are good. The medications are necessary and helpful. If, however, these children keep away from their allergens they do not get the first phase and consequently avoid the second phase. Penicillin then becomes unnecessary. If this were an isolated experience I would not mention it. But these are clearly repeated events and the mothers now report that they know why their children are ill.

TONSILLECTOMY is a pertinent question. Parents come to ask how soon the tonsils can be removed. I have seen too many removed unsuccessfully. Some children develop their first attacks of asthma after tonsillectomy. Yet tonsillectomy is often needed urgently. On the other hand, if the allergic picture is controlled first, by diet and by household precautions (in other words, if the house is made a little less dusty and the intake of the allergenic foods is restricted) the results are much nicer to look at and many may avoid surgery entirely. Control the allergy and get a nice job; neglect it and get a poor one.

I have emphasized the pediatric phase of these problems because I am most familiar with them, but I do see some of the parents at times and their symptoms respond to the

management they have been taught to give their children.

It is not my contention that all the things I have mentioned are bad in themselves. I only ask that their use be limited. Too many mothers brag about how their children refuse to eat but they get their milk. If they balk at white milk, the mother fools them by giving chocolate milk or egg-nog. They think they fool the children; but the parents are fooling only themselves. If the child says "no" to a food, respect his wishes. An infant a few weeks old knows what to refuse. Similarly, a careful use of feathers, rug pads and soft wool clothes will produce few symptoms. It is the over-use which causes trouble.

Skin tests are helpful in reaching some conclusion. But if tests for milk and chocolate are not strongly positive, it is my custom to restrict them until I can relieve the symptoms, and then carefully re-introduce them into the diet. The quantity is often important in producing symptoms. In differential diagnosis, fever is frequently considered to be an indication of whether the case is allergic or infectious. It is a dangerous index. One boy I saw recently ran a fever for four months up to 105 degrees daily. There was no evidence of infection found at one of the large New York City hospitals, nor at the hospital where he was first admitted for study. He was sent home with a bad prognosis and recovered in five days with proper diet. Dietary indiscretions reproduced the symptoms a year later but not to such a severe degree.

Special staining technics to demonstrate eosinophiles have been recommended. In some hands, they produce good results but it is not my practice to depend too much on them. I am more content to look, feel and smell. The foul throat and the severe halitosis are useful indications. It does not matter whether the patient is sensitive to foods or inhalants; the telltale odor spells allergy.

Molds have a place in colds, I am sure, but my experience with them has been not nearly as dramatic and exciting. Also, I discount bacterial allergy as a major factor in colds. I have used no stock or autogenous vaccines in the past four years.

A careful evaluation of your patient's symptoms will give you many clues. Follow the leads. Get a good history and the patient will frequently make the diagnosis.

Why do colds run through families? While I do not deny the possibility of a cold virus I recognize that (1) allergy is a family affair, (2) people living in the same house are subject to pretty much the same conditions of environment and food. Is it unreasonable to argue that things which affect one member of a family are likely to affect the others? In addition, influenza by whatever name it is called is contagious and it is subject to wide variations in virulence.

In closing, I want to repeat that proper regard to diet and environment will reduce greatly the number of annoying bothersome symptoms about which your patients complain. Teach them moderation in all these things and they will be healthier and happier and so will you.

385 Clifton Avenue

Syphilis Films Available

Available for showing at medical groups is a new 16 millimeter sound film on the diagnosis of syphilis by general practitioners. The film demonstrates the technic of the darkfield examination and portrays other aspects of differential diagnosis. Application for use of the film is made to the New Jersey State Museum, State House Annex, Trenton, N. J. The film is available without charge other than the cost of the postage.

Victor H. Miles, LL. B.
Newark

Are Your Records Immunized Against Cross Examination?

Mr. Miles, a Newark trial attorney, presents one small phase of the medico-legal aspects of record keeping: the office record's vulnerability to cross-examination. He also, and quite properly, emphasizes the moral obligation of the physician to go to court on behalf of a patient, rather than to let him suffer injustice because of the doctor's unwillingness to serve as a witness. We think Mr. Miles has over-emphasized the "padding" of records, since few doctors are guilty of this. But it would be folly to close our eyes to the fact that it sometimes does happen.

Some doctors welcome the challenge of cross-examination as a medium to confirm their professional skill. To others it is anathema. This unwarranted trepidation may be overcome if we isolate and expose its etiology.

An analysis of each incident wherein the doctor complains of being embarrassed, humiliated or degraded reveals that vulnerability to attack often results from incomplete or inaccurate records.

At times, sympathetic doctors capitulate to the pleas of their patients: "Doctor, won't you please submit a *good* report to the insurance company?" The long-time family physician with his magnificent loyalty to an old patient may easily see it as the patient does. But the insurance company's examining physician belittles the injuries and the company refuses to consider settlement.

Perhaps the doctor can justify his report at the time of trial by some rationale. But I have actually seen "padded" treatment recorded hastily without adequate explanation or description, obviously tacked on to an office record.

The practitioner sometimes brings his original record into court containing cryptic symbols or abbreviated notations. On direct examination in court, these brief comments may suddenly burgeon forth into pages of oral testimony. Then the cross-examiner requests permission to examine the records and casually inquires: "Doctor, is all the treatment of which you have just testified written in your report?" You say: "No, time does not permit me to make detailed reports in every case, but I remember the facts of this case very clearly." Then the question is asked: "Doctor, how many patients do you treat daily?" The doctor with pride answers 20 to 30, and the advocate multiplies rapidly to produce a figure of 9,000 per year and then caustically injects: "Doctor, this treatment was rendered 15 months ago and since then you've had over 10,000 patient-contacts. Can you recall as readily the facts concerning each of those patients?" The impression on the jury is obvious. The doctor thereafter keeps more detailed records.

Where reports of examination may, by law, be exchanged between opposing counsel, be

certain that they are complete. Such records mirror the ability and sincerity of the physician. If you represent an insurance carrier, do not append any confidential memorandum to the main report which contains a modified opinion designed for the personal interest of the carrier.* These memos have a faculty of falling into the hands of persons for whom they are not intended. Also, it is a favorite question on cross-examination to ask: "Doctor, didn't you submit some additional reports on plaintiff's condition?"

Attorneys who specialize in personal injury work, often have extensive medical libraries. They know about the availability of medical text books and periodicals in hospitals and medical academies. They are surprisingly familiar with the generally accepted methods of examination and treatment in traumatic cases. Every part of your record will be subjected to scrupulous inquiry. It is not enough that you actually performed each essential requirement. It must be distinctly noted on your record to eliminate any possible inference of bias in your testimony. Printed forms or check lists are time-saving devices.

The taxpayer who fails to keep proper records of his financial transactions subjects himself to fine and imprisonment. The physician who fails to keep proper records of his treatments places his patient's life in jeopardy. Surely, a physician's obligation to keep proper records is the greater even though it may appear ancillary to his profession.

The amount of an award depends upon the attorney's effective presentation and demonstration of the nature of his client's injuries to the jury. Verdicts of $5,000 and $100,000 have been returned by different juries for similar injuries. The disparity in verdicts may be attributed, in great measure, to differences in the adequacy of the presentation of medical testimony.

It is surprising to hear of the physician who declines to accept a patient if the possibility of litigation exits; or the one who treats a patient on condition that another physician will be called to testify in the event of trial. This attitude is not consonant with the Hippocratic oath by which the doctor has vowed to:

> "**follow that system of regimen, which according to my ability and judgment, I consider for the benefit of my patients.**"

The physician's testimony is often as essential to the patient as the treatment for his injuries. The working capacity of many a wage-earner has been completely destroyed as a result of an accident. His medical rehabilitation is of minimal value without the economic sustenance of a just and adequate money verdict.

*Perhaps the author is not entirely clear here. Sometimes a physician sends a health insurance company a report correctly reflecting a hopeless and fatal disease. For humanitarian reasons, he shrinks from letting the patient know this. Perhaps the formal report to the company has to pass through the patient's hand for countersignature. It would be brutal to put the naked truth on such a form. So the conscientious physician may send directly to the company a confidential memorandum indicating that the "chronic pancreatitis" on the formal report is actually a metastatic carcinoma of the pancreas. This is not the kind of confidential report which Mr. Miles deplores. What he has in mind—I think—is this: in his formal report the doctor says: "Concussion of the brain, mild, transient; recovery should be complete." In a confidential memorandum to the adjuster, he says: "This man has a laceration of the brain with actual destruction of some cortical tissue. Since central nervous system tissue never regenerates, he's going to have a substantial permanent disability, and you'd better settle. An actual description of the disability would sound pretty bad before a jury, so keep it out of court if you possibly can." This kind of double-talk is properly condemned.—Editor.

Irving Lerman, M.D.
Samuel Lerman, M.D.
Frederick Lerman, M.D.
Elizabeth

Retrocaval Ureter*

Seldom thought-of, but not actually rare, retrocaval ureter is a treatable condition. The Doctors Lerman here indicate when to repair the kidney and when to remove it; when to look for lysis of adhesions and when to section the inferior vena cava.

Up to February, 1955, only 58 cases of retrocaval ureter had been reported in the literature. However, we have seen two cases in the past two years. We cannot assume our experience to be unique. Conversations with other urologists reveal that most of them have seen at least one case each. It must then be assumed that the anomaly is much more prevalent than heretofore reported. Thus retrocaval ureter should no longer be considered as rare, though it is certainly infrequent.

The term *retrocaval ureter* actually embraces two conditions:

(1) Classical retrocaval ureter, in which the right ureter courses downward and inwards, crossing behind the inferior vena cava to its medial aspect, after which it winds around the vena cava by crossing it anteriorly to its lateral aspect again. Below that point it proceeds along its normal course to the bladder. For our own clarification we designate this as "circumcaval ureter."

(2) In some cases, the ureter courses medially downward to disappear behind the inferior vena cava, proceeds behind it for varying distances and then emerges back to its normal lateral course without winding around the vena cava. We call this "postcaval ureter."

ETIOLOGY

Circumcaval ureter is a developmental anomaly of the embryonic vascular system. The permanent kidney (the metanephros) develops in the pelvis of the embryo and ascends to its eventual lumbar position. During ascent it passes through a ring of veins. One of these is the postcardinal vein. The kidney ascends anterior to this vein and crosses to its medial side; it then goes posterior to the vein and crosses to its lateral side, winding around the vein. Thus, retrocaval ureter is produced. The condition does not persist commonly because the usual development is for this postcardinal vein to atrophy and disappear and for the definitive inferior vena cava to be formed from a different vein—the supracardinal vein—which lies posterior to the ascending kidney. It is when the postcardinal vein persists to form the inferior vena cava that the anomaly occurs.

In postcaval ureter, the kidney may ascend abnormally so that it becomes situated posterior to a normally formed inferior vena cava. Or postcaval ureter may be acquired due to adhesions secondary to such conditions as appendicitis or ureteritis.

*Read before the Section on Urology, 189th Annual Meeting of The Medical Society of New Jersey, April 20, 1955.

SYMPTOMS

THE positioning of the ureter leads to obstruction because of either compression, or kinking, or both. Obstruction in turn leads to hydronephrosis, calculosis, or infection. Thus, any of a varied group of symptoms may occur —backache, lumbar pain, frequency, dysuria, albuminuria, pyuria, hematuria, and (in one of our cases) diurnal incontinence. When pain occurs it is on the right side, because all reported cases except one have been on the right side. That one exception was a case of bilateral retrocaval ureter which occurred in an acardiac fetus.

Most cases develop symptoms in early adult life, presumably because it takes time for the hydronephrosis to develop. A few cases have been described showing symptoms under the age of 12 years. One of ours was 6½ years old.

DIAGNOSIS

THE condition should be suspected in all cases of unilateral right hydronephrosis. Diagnosis is made by x-ray. The classically described findings are:

(1) In the antero-posterior view there is a hydronephrosis with the upper ureter dilated and the lower ureter either normal or failing to visualize.

(2) In the same view there is an S-shaped curve of the upper ureter which extends to or beyond the midline of the patient's body.

(3) In the right oblique view the ureter impinges on the vertebral bodies beginning with L-3 or L-4. Normally, the ureter courses anterior to the vertebral bodies in this view.

There is one other diagnostic aid. With a radio-opaque catheter left *in situ* in the right ureter, Diodrast® is injected into the femoral vein. A vena cavogram thus obtained will reveal the relative positioning of the ureter and inferior vena cava.

TREATMENT

1. In many cases the pathology has progressed to a point where *nephrectomy* is the treatment of choice.

2. If renal salvage is possible *plastic repair* is undertaken. Various types of ureteral section with re-anastomosis after unwinding the ureter from the inferior vena cava have been described. In these operations, the incidence of postoperative stricture formation necessitating secondary nephrectomy has been high. A better method is to section the renal pelvis and then re-anastomose it after uncoiling the ureter. Results are superior since the large lumen prevents destructive stricture formation.

3. *Section of the inferior vena cava* should be considered only (1) when the opposite kidney has insufficient function to sustain life. In that case the surgeon may be justly fearful of operating on the one vital kidney. (2) In the rare anomalous case where there is reduplication of the inferior vena cava.

4. The postcaval ureter is readily treated by a *lysis of adhesions*.

CASE ONE

A 6½ year-old boy was first seen in November 1952 because of diurnal urinary dribbling of 2 years' duration, and urinary frequency with burning and dysuria of 2 months' duration. Physical examination was normal. The urine showed only a faint trace of albumin and no pus cells. Intravenous urography (Fig. 1,a) showed the classical dilatation of the right renal pelvis and upper ureter, with S-shape, medial coursing of the right ureter, and failure of the lower ureter to visualize. Cystoscopy revealed a normal urethra and bladder. Indigo carmine injected intravenously appeared at the left ureteral orifice in 3 minutes; there was none coming out of the right ureteral orifice even after 20 minutes. A 4-F ureteral catheter would advance only 10 centimeters up the right ureter, and there was no drainage through it at that point. A survey film (Fig. 1,b) showed the catheter crossing the midline to the left side—so much so that the roentgenologist interpreted the film as catheter in the left ureter. Retrograde pyelography was unsuccessful; the dye failed to advance beyond the tip of the catheter.

The pre-operative diagnosis was circumcaval ureter.

At surgery, classical circumcaval ureter was found. The ureter was sectioned at its widest upper part. The lower segment was brought around the inferior vena cava and an end-to-end anastomosis was performed. Convalescence was uneventful. A mild pyuria appeared postoperatively and persisted for one month. His symptoms—including the urinary dribbling—disappeared completely while he was still in the hospital. An intravenous urogram about 5 months postoperatively (Fig. 1,c) showed persistent dilatation, but the ureteral course was normal and the lower ureter was seen entering the bladder. The latest follow-up intravenous urogram, done 2 years postoperatively on February 1, 1955, (Fig.

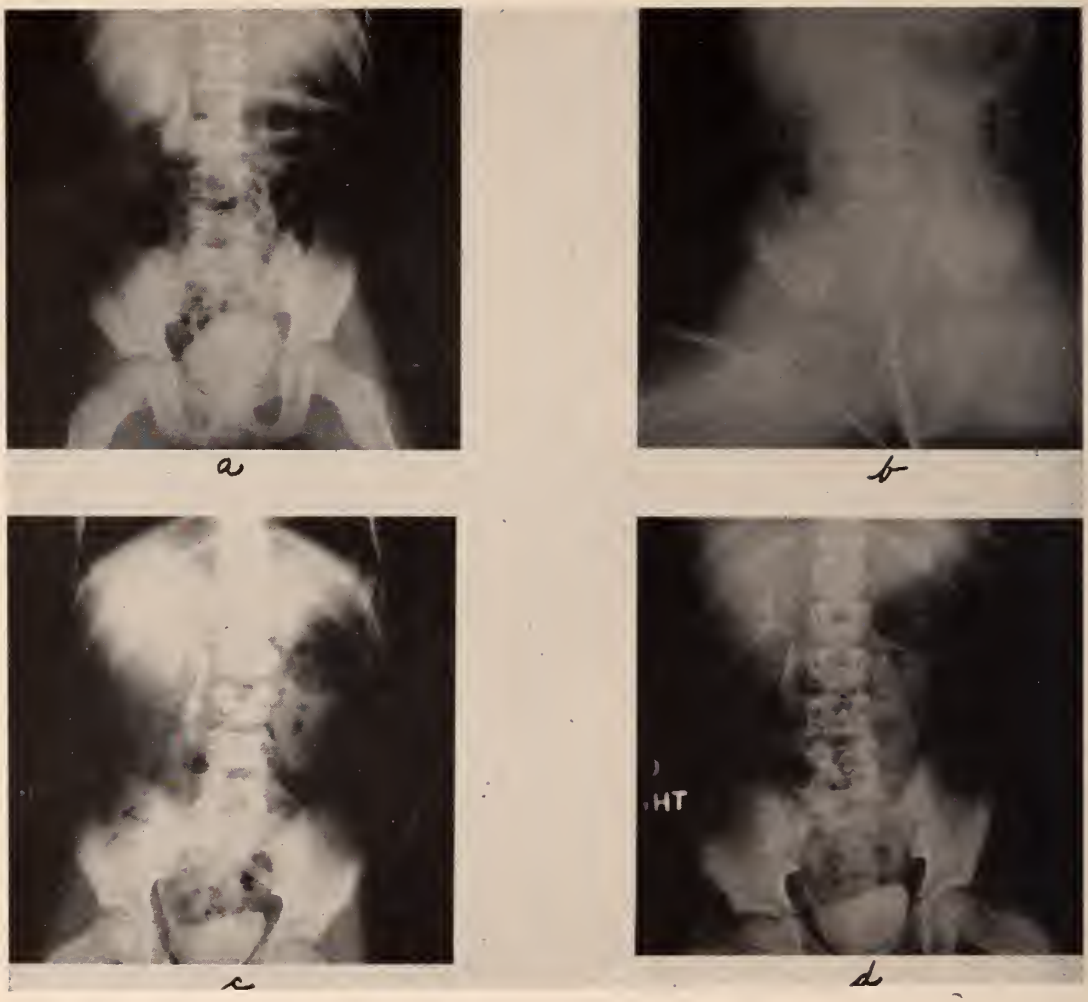


Figure 1.

1,d) was essentially normal, showing only some residual dilatation of the right upper ureter.

CASE TWO

A 26-year old male was seen because of a persistent 4 plus albuminuria. He had no other symptoms. Past history revealed only a routine appendectomy 5 years earlier. Physical examination was normal. The urine showed only 4 plus albumin. Intravenous urography again showed the classical picture of retrocaval ureter. (Fig. 2,a) Cystoscopy revealed a normal urethra and bladder. Bilateral retrograde ureteral catheterization was performed with 5-F ureteral catheters. The left catheter ascended readily and the urine from that kidney contained only a trace of albumin. The catheter on the right side met a slight obstruction at 15 centimeters. This was passed without difficulty and then the catheter ascended readily to the renal pelvis. The right kidney urine contained 4-plus albumin. The ureteropyelogram (Fig. 2,b) showed the medial deviation of the right ureter.

The right catheter was left *in situ* and a vena cavogram was then obtained. It showed the ureter to be in almost normal position. (Fig. 2,c) It was thus assumed that the ureter, while retrocaval, was not circumcaval, and that the stiff catheter had managed to straighten it out temporarily. Pre-operative diagnosis was postcaval ureter.

At surgery, postcaval ureter was found. The adhesions binding the ureter and the inferior vena cava were easily separated and the peri-ureteral tissues were then lightly sutured to the psoas fascia to insure a normal course for the ureter. Convalescence was uneventful. One month postoperatively the urine contained just a trace of albumin. Intravenous urography (Fig. 2,d) and retrograde pyelography revealed some persistent dilatation, but the function was normal and the ureteral course was near normal.

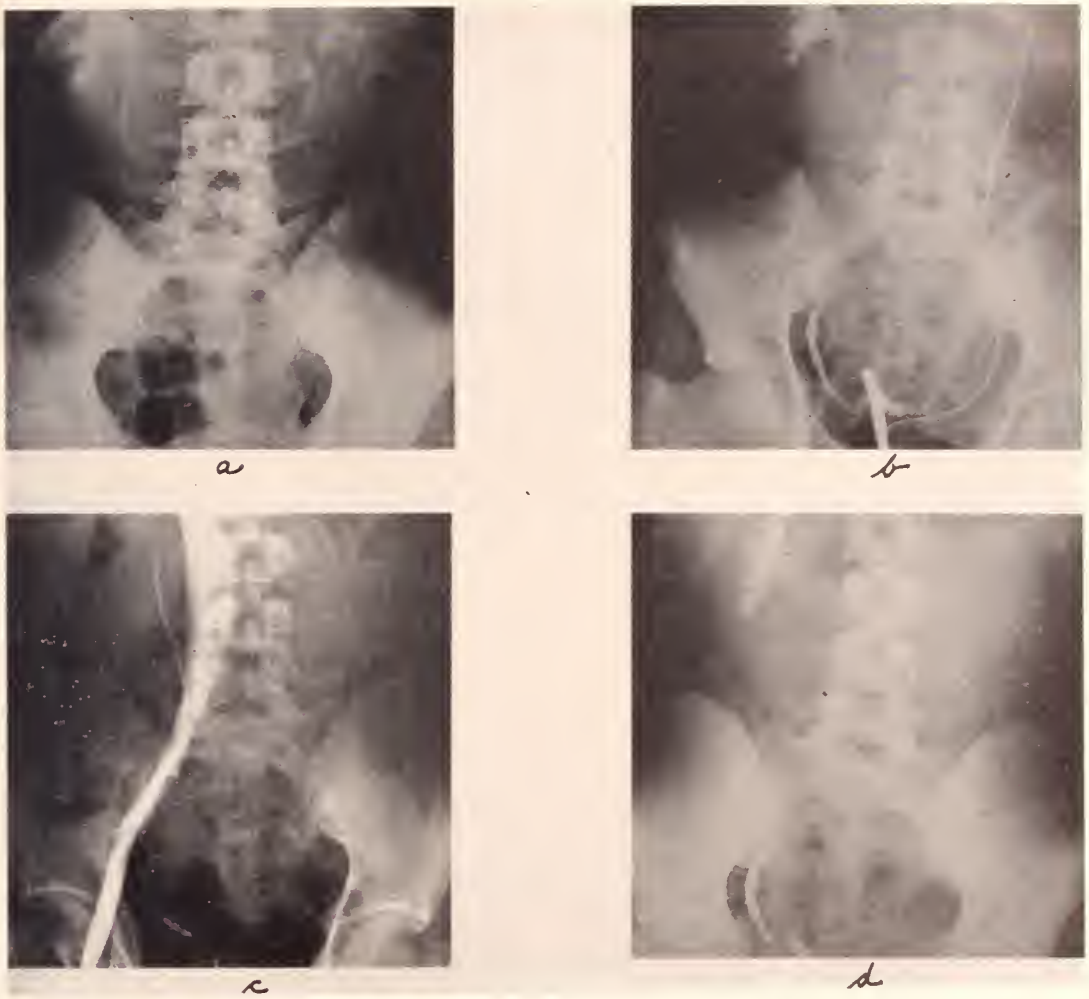


Figure 2.

SUMMARY

Retrocaval ureter is not a rare condition. All urologists should be aware of it. Diagnosis is simple once the condition is suspected. Treatment depends on the type and degree of pathology found.

1024 East Jersey Street

Reaction to Mercurial Diuretics

It is unwise to consider mercurial diuretics as a group. Newer compounds are organic complexes which act selectively at different sites in the kidney and have a wide range of diuretic potency not necessarily related to equivalent mercury content. The term "hypersensitivity" is too often applied to any mercurial diuretic reaction when in fact the drug is rarely responsible. Serious reactions can usually be avoided by careful attention to route of administration, dosage, and early recognition of the truly allergic subject. "Drug reactors" can be detected by intradermal injection of 0.05 cc. serum obtained from a nonsensitive patient taking the mercurial in question. Sensitivity is indicated by development of a characteristic wheal.

Abstracted from paper by E. A. Brown in the Annals of Allergy, 13:131 (1955).

S. J. Fanburg, M.D.
Newark

Response of Seborrheic Dermatitis, Dandruff, and Pyodermas to a Form of Sodium Sulfacetamide*

The preferred treatment for dandruff and for seborrheic dermatitis is, according to this report, a 10 per cent sodium sulfacetamide lotion. The merits of this new preparation are here eloquently spelled out. As usual, psoriasis did not respond.

Sebizon®* lotion is a new preparation containing 10 per cent sodium sulfacetamide. While the antibacterial activity of this substance topically has long been utilized in ophthalmic infections,[1-7] its application has only recently been extended to seborrheic dermatitis and dandruff.[8] Besides a high degree of antibacterial activity upon local application, this sulfonamide enjoys the advantage of a low incidence of sensitivity reactions. "Local sensitivities frequently noted with other sulfonamides rarely are encountered with sodium sulfacetamide."[9] Duemling[8] discovered the effectiveness of sodium sulfacetamide in an itching, scaling eruption of the scalp and skin under these circumstances: a patient with a severe conjunctivitis and blepharitis, complicating an impetiginized seborrheic dermatitis, applied a 10 per cent sodium sulfacetamide ointment to his skin. Within a week, the conjunctivitis and blepharitis had cleared and the serous oozing and crusting in other involved areas were controlled. This led to a study of the effectiveness of sodium sulfacetamide topically in seborrheic dermatitis and in primary bacterial cutaneous infections. While sodium sulfacetamide had been demonstrated a long while ago to be effective in bacterial infections of the skin[10-13] and in the prophylaxis of infections in burns[14,15] and wounds,[16,17] its dermatologic applications were apparently not being utilized to the fullest extent. Perhaps the field for its use was being pre-empted by the antibiotics. Duemling[8] controlled seborrheic dermatitis in 46 of 76 patients with sodium sulfacetamide ointment and shampoo. The drug in ointment form also controlled folliculitis, impetiginized dermatitis, neurotic excoriations, sycosis vulgaris, and otitis externa in 4 of 5 patients in his series.

The experience of other investigators as well has led to reports that in seborrheic dermatitis a 10 per cent sodium sulfacetamide lotion (Sebizon®*) "is extremely effective both

*Sebizon® lotion was the form of sodium sulfacetamide used here. It was kindly furnished by G. Kenneth Hawkins, M.D., Division of Clinical Research, Schering Corporation, Bloomfield, N. J.

on the scalp and skin"[18] and that it controls "recurrent vesicular eruptions on the scalp."[19] Some of the 123 cases of otitis externa reported by David[20] were caused by dandruff of the scalp. The otitis externa was cleared in 88 patients by the use of sodium sulfacetamide topically.

MATERIAL AND METHOD

Sodium sulfacetamide as Sebizon®* lotion 10 per cent was used in the treatment of 62 men and 88 women with the following diseases: seborrheic dermatitis 69; seborrhea sicca or oleosa 37; psoriasis 9; pyoderma or acne 20; and miscellaneous dermatoses 15.

Patients with seborrheic dermatitis or with dandruff, applied Sebizon®* lotion to the scalp or other affected areas once daily. They shampooed their hair once a week. They usually found that after the initial applications, they did not need to apply it so frequently. In most cases, dandruff was controlled by applying Sebizon®* every other day or three times weekly. The lotion was applied daily in cases of psoriasis and twice daily in the pyodermas, acnes, and miscellaneous dermatoses.

Directions were to rub the lotion into the skin until the area became dry. When this was done, no trace was detectable on the skin. On the scalp, it acted as a hair dressing but did not make the scalp or hair oily or greasy.

RESULTS

Seborrheic dermatitis affected the scalp in 46 patients, the scalp and face, ears, or neck in 11, the scalp and various body areas in 10, the ears in one patient and the chest in another. In all, there was a severe widespread dermatitis with redness and inflammation.

When Sebizon®* lotion was used as directed, seborrheic dermatitis was relieved and could be kept under control by use of the lotion about once a week. As the accompanying table shows, 64 of the 69 patients with seborrheic dermatitis responded to treatment with sodium sulfacetamide. An especially severe eruption on the scalp and ears in one patient was completely cleared by treatment for four weeks. The disease in 5 patients was unchanged. In one, itching grew worse during a week's application of Sebizon®* so that the lotion was discontinued. Duration of treatment varied from two to twelve weeks; 70 per cent of the group required treatment for four to six weeks for satisfactory control of the disease on the scalp or body areas. Once control of the dermatitis was achieved, it could be maintained by applications of the sodium sulfacetamide at intervals of one week to ten days. If the medication were stopped, the dermatitis tended to recur.

SEBORRHEA SICCA AND OLEOSA

Seborrhea sicca or oleosa affected 37 patients. The complaints of these patients were of common dandruff with scaling and flaking in 8, scaly scalp in 22, oily scalp in 2, scaly encrusted scalp in 2, and itching scalp in 3. With daily applications of the sulfacetamide, these conditions cleared in 36 of the patients so that less frequent use was required. Itching usually disappeared quickly. In one 34-year old male with scaling of the scalp, itching persisted despite diminished scaling. One patient in this group improved within a week. The others needed four to six weeks' treatment for satisfactory results. These conditions could also be kept under control by the intermittent application of the sulfacetamide lotion and tended to recur if it were omitted.

PSORIASIS

Psoriasis proved refractory to treatment with Sebizon®* in all nine patients on whom it was tested. They failed to improve with treatment for two to five weeks. One patient developed more scales during one week's application of Sebizon®* so that the lotion was discontinued.

ACNES AND PYODERMAS

TWENTY patients with bacterial infections of the skin were treated with Sebizon®.* This group included: cystic acne, 3; pustular acne, 3; infected atopic dermatitis, 1; infectious eczematoid dermatitis, 4; infected excoriations, 1; impetigo of the scalp, 3; impetigo of the face and scalp or neck, 2; pyoderma of the face and scalp, 1; sycosis nuchae, 1; and sycosis of the face, 1.

Results in general were good. The lesions healed in 12 of the patients and remained healed without further treatment.

The pustular element in cystic acne was controlled in one patient and reduced in two by treatment with sodium sulfacetamide lotion for four weeks. Pustular acne improved in four and six weeks, respectively, in two patients. A third patient with this type of acne applied the lotion for four weeks with only slight benefit. In one case of atopic dermatitis with secondary infection, the infection cleared in two weeks but the eczema remained unchanged.

Infectious eczematoid dermatitis of the ears in a 52-year old woman cleared within a week. The disease affected the legs in another patient and showed only moderate improvement when Sebizon®* was applied for two weeks. An elderly male with disease of the face and ears improved slightly in two weeks. Another, age 80, had no benefit from treatment for a week.

Infected excoriations in one patient healed in a week. The impetiginous lesions in 5 patients healed in four to seven days. Sebizon®* lotion eradicated pyoderma of the face and scalp in a 3-year old child when it was applied for seven days. Sycosis nuchae and sycosis of the face in two males failed to respond to treatment for two weeks.

DERMATOSES

DERMATOSES with an element of infection responded favorably. Thus, in 2 patients with folliculitis of the neck and crotch, the eruption faded and disappeared. A 57-year old female patient with intertrigo and several complicating conditions benefited from the use of sodium sulfacetamide for two weeks. The intertrigo, however, recurred when she stopped using the lotion. In one case of pemphigus, the lotion soothed the crusted areas but in another had no effect on the lesions. A diabetic ulcer in a 58-year old male healed with treatment for four weeks.

Alopecia areata, lichenified dermatitis, chronic and nummular eczema, and pompholyx in the few patients treated with each failed to respond. A patient applying sodium sulfacetamide for eczema of the ankle without benefit developed a severe generalized dermatitis. This was the only reaction of any kind to the application of the lotion and necessitated its discontinuance.

COMMENT

SODIUM sulfacetamide lotion provided an excellent result in seborrheic dermatitis and in seborrhea sicca and oleosa. It is now preferred to other therapeutic agents. Brought under control with the sulfacetamide, these conditions could be controlled with application of the lotion once weekly. Its use was satisfactory in cutaneous bacterial infections as the lesions healed in 12 of the 20 patients so affected and improved in an additional five. It was of no value in psoriasis or in dermatoses where no infectious element was present.

Most of the patients in this study liked the lotion. They liked its ease of application and the lack of odor. The lotion was cosmetically acceptable. It left no greasy residue. The fact that it could be rubbed into the skin or scalp until it disappeared was a definite advantage.

Some patients cannot apply sulfonamide drugs locally because of the likelihood of sensitivity reactions. The high incidence of such reactions to sulfonamide preparations designed for topical applications has led to their exclusion from *New and Nonofficial Remedies*.[21] Sodium sulfacetamide is an exception to this. Wide clinical application attests to the low incidence of sensitivity reactions with its use

topically.[22,23] This advantage applies as well to the drug in lotion form.

SUMMARY

A 10 per cent sodium sulfacetamide lotion (Sebizon®*) satisfactorily improved 64 of 69 cases of seborrheic dermatitis and 36 of 37 cases of seborrhea sicca or oleosa of the scalp. Treatment for four to six weeks was usually required for satisfactory control which then could be maintained by application of the lotion once a week. The superior result makes this a preferred therapeutic agent in seborrheic dermatitis and cases of ordinary dandruff. Bacterial cutaneous infections healed in 12 of 20 patients treated with the sulfacetamide lotion and were improved in 5 additional patients. Dermatoses with an element of infection, such as folliculitis, responded but psoriasis and some other dermatoses proved refractory. One patient among the 150 treated in this series developed a sensitivity reaction, a severe generalized dermatitis.

TABLE 1. RESULTS OF TREATMENT OF SEBORRHEIC DERMATITIS, DANDRUFF, AND VARIOUS DERMATOSES WITH SODIUM SULFACETAMIDE

	No. Pts.	Duration of Treatment	Result: Satisfactory Improvement	Result: Slight Improvement	Result: No Change
Seborrheic Dermatitis:					
Scalp	46	2 wks.— 2 3-4 wks.—24 6-8 wks.—18 12 wks.— 2	46	0	0
Scalp and face, ears, or neck	11	1-2 wks.— 3 3-4 wks.— 5 6 wks.— 3	8	0	3a
Scalp and body areas	10	2 wks.— 2 4 wks.— 4 6-8 wks.— 4	8	0	2
Ears	1	8 wks.	1	0	0
Chest	1	2 wks.	1	0	0
Total	69		64	0	5
Seborrhea Sicca or Oleosa:					
Dandruff	8	4 wks.— 7 5 wks.— 1	8	0	0
Scaly scalp	22	2 wks.— 1 4 wks.—15 6 wks.— 6	21	1b	0
Oily scalp	2	4 wks.	2	0	0
Scaly crusted scalp	2	4 wks.— 1 6 wks.— 1	2	0	0
Itchy scalp	3	4 wks.	3	0	0
Total	37		36	1	0
Psoriasis	9	1 wk. — 1 2 wks.— 5 3 wks.— 1 4 wks.— 2	0	0	9c

a. Itching made worse in 1 patient.
b. Scaliness diminished, complained of itching.
c. One patient developed more scales during treatment.

	No. Pts.	Duration of Treatment	Result: Satisfactory Improvement	Result: Slight Improvement	Result: No Change
Acnes and Pyodermas:					
Acne, cystic	3	4 wks.	1	2	0
Acne, pustular	3	4 wks.— 2 6 wks.— 1	2	1	0
Atopic dermatitis, infected	1	2 wks.	1d	0	0
Eczematoid dermatitis, infectious	4	1 wk. — 2 2 wks.— 2	1	2	1
Excoriations, infected	1	4 das.	1	0	0
Impetigo, scalp	3	4-5 das. — 2 1 wk. — 1	3	0	0
Impetigo, face and scalp or neck	2	4-5 das.	2	0	0
Pyoderma, face and scalp	1	1 wk.	1	0	0
Sycosis nuchae	1	2 wks.	0	0	1
Sycosis, face	1	2 wks.	0	0	1
Total	20		12	5	3
Dermatoses:					
Alopecia areata	1	4 wks.	0	0	1
Dermatitis, lichenified	1	2 wks.	0	0	1
Eczema	3	1 wk. — 1 4 wks.— 2	0	0	3e
Eczema, chronic	1	2 wks.	0	0	1
Eczema, nummular	2	2 wks.	0	0	2
Folliculitis	2	1 wk. — 1 4 wks.— 1	2	0	0
Intertrigo	1	2 wks.	1	0	0
Pemphigus	2	2 wks.— 1 4 wks.— 1	1	0	1
Pompholyx	1	4 wks.	0	0	1
Ulcer, diabetic	1	4 wks.	1	0	0
Total	15		5	0	10

d. Infection cleared in one week, eczema unchanged after two weeks.
e. Treatment discontinued in 1 patient who developed a severe generalized dermatitis.

31 Lincoln Park

An extensive bibliography appears in the author's reprints.

Ultrasonic Visualization of Living Tissue

Howry and three other University of Colorado staff members* recently developed an ultrasonic instrument (somascope) for visualization of soft tissue structures and disease processess in the living body. The visualization method is similar to the echo-ranging technics of sonar and radar. Pictures obtained with the present instrument show such structures as nerves, arteries, veins, and muscles and disease processes such as cirrhosis and carcinoma of the liver. The ultimate goal is development of an instrument that will permit the *in vivo* study of soft tissue anatomy and pathology in a manner comparable to actual sectioning of the gross structures in the laboratory.

*Howry, D. H. *et al.*: Geriatrics, 10:123, April 1955.

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The Present Status of Atopic Dermatitis*

Is atopic dermatitis allergic, emotional, or infectious? Dr. Baer refuses to accept a single simple cause and discusses the ways in which many factors contribute to the disease. A common sense treatment regime is also outlined.

Atopic dermatitis has, at various times, been known by a variety of names including disseminated neurodermatitis, lichen Vidal disseminatus, hay fever-asthma-eczema and flexural eczema. Clinically, this dermatosis changes its appearance and localization in various age groups. In infants for example it presents the typical atopic infantile eczema with papular and vesicular, erythematous, weeping and crusting lesions, mainly on the face and scalp, not infrequently on the trunk and extensor aspects of the extremities. In children, involvement is found principally in the cubital and popliteal spaces, on the back of the neck and on the wrists. The lesions then tend to be lichenified, thickened, erythematous and papular. In adolescents and adults there are usually erythematous and lichenified plaques involving the face, neck, cubital spaces, wrists and pubic area. In all age groups, but especially in adolescents and adults, there is often also a pronounced seborrhea of the scalp.

Since atopic dermatitis tends to occur especially in certain age groups, one can roughly differentiate between the infantile eczema form in the first and second years of life, the childhood form between six and ten, the adolescent form between twelve and eighteen and finally the adult form. That an infant has had atopic dermatitis does not necessarily mean that he will develop the eruption again later in life. Nor does the fact that one has *not* had infantile eczema preclude the development of atopic dermatitis in childhood, adolescence or later. As a rule, the skin of patients with atopic dermatitis clears in their late teens or early twenties. Fortunately only a small number continue to suffer the eruption beyond that age.

The one feature which seems to be shared by most cases of atopic dermatitis and which gives the disease its name is their "atopic diathesis." This expresses itself in a familial and personal tendency to allergic asthma, allergic rhinitis and atopic dermatitis, in urticarial responses in skin tests with common protein food, inhalant and contactant allergens and in the frequent finding of passive transfer antibodies in their blood serum. It is important also to remember that, while any patient may develop serum sickness-like allergic reactions to foreign sera, penicillin and other drugs, the rare near-fatal or fatal reactions to foreign sera and penicillin are usually seen in patients with the "atopic tendency."

Although these well known and conspicuous immunologic stigmata are present in many patients with atopic dermatitis, the disease is not simply an allergic eruption. In our experience it cannot be shown reliably in most patients that allergic factors play a causal or contributory role. Skin tests are so unreliable as indicators of *clinical* sensitivity that their routine use for finding causal or contributory agents has been abandoned by me as well as

*Read April 18, 1955 at the Section on Allergy, Annual Meeting, The Medical Society of New Jersey.

by many others. Many of these patients respond with urticarial reactions to skin tests with food, inhalant and other allergens; still, when they are exposed clinically to these particular foods, inhalants or contactants there is usually no exacerbation of the eruption. Moreover, patients with clinical sensitivity to one or more allergens have been known to have had negative skin tests to these particular allergens. However, in some patients with atopic dermatitis, allergenic factors contribute to the maintenance of the eruption and produce exacerbations. Foods are most important in this respect in infants and young children. Inhalants more often play a role in older children, adolescents and adults. While we have given up the *routine* use of skin tests in atopic dermatitis we sometimes perform them in severe and persistent cases, in the hope that they may occasionally give us a helpful lead.

Atopic dermatitis is sometimes aggravated by wearing woolen clothing. This may be due to allergenic activity of the wool fiber or friction or both. In particular, lesions on the wrists and sides and back of the neck should arouse suspicion regarding a possible contributory role of wool. Some think that wool may be important even as an inhalant allergen in atopic dermatitis.

IN recent years a number of other, apparently non-immunologic, stigmata in patients with atopic dermatitis have been discovered. We are in the dark regarding their incidence in the various age groups and it is not known whether several or all these stigmata are part of the mechanism which produces atopic dermatitis or whether they are a consequence of the disease. A number of them have an important bearing on the physiologic functions of the skin.

For example, patients with atopic dermatitis usually show white dermographism. If the affected skin is stroked lightly with a fingernail there develops a conspicuously white reaction, due to a *spasm* of the blood vessels, instead of the usual red reaction *i.e.* the vasodilatation which is normally the first phase of Lewis' triple response. Another part of this peculiar vascular response is an absence or diminution of the erythematous flare in wheal reactions, *i.e.* the third part of Lewis' triple response. This applies to skin test reactions to allergenic agents such as foods as well as to non-allergenic but primary urticariogenic agents such as histamine. Abnormal responses have been found also in the cold pressure test and in the skin temperature adjustment. Upon cooling the skin temperature tends to undergo an abnormally rapid drop and upon rewarming an abnormally slow rise. In the cold pressure test both the systolic and diastolic blood pressure rise higher than normal, although in general there appears to be a tendency to low blood pressure in these patients.

HIGHLY important among recently discovered non-immunologic stigmata are certain disturbances in the sweat mechanism. Clinical examination of the sides of the trunk of some children and adolescents with atopic dermatitis shows them to be studded with innumerable skin colored papules some of which presumably are plugged sweat pores. That this is so has been demonstrated in histologic examinations as well as in sweat tests *in vivo* carried out by modern methods. This disturbance in sweating produces a number of serious consequences which may account for some of the clinical features of atopic dermatitis. Sweat which cannot escape through the pores apparently produces not only pressure in the epidermis and stimulates the nearby nerve endings, but also causes a disruption of the normal anatomic structure of the sweat duct in the epidermis. Furthermore, inability to deliver sensible sweat to the skin surface is bound to interfere with the normal cooling process which occurs when sweat evaporates from the skin surface.

Recently the possibility has been suggested that sweat perhaps contains small amounts of allergenic materials which normally are excreted to the surface but which, if the sweat cannot escape through the plugged pores, are "self-injected" into the skin in millions of sites.

Atopic dermatitis patients also have a tendency to "flat" blood sugar curves. The significance of this is not known. Another important stigma is the unusual susceptibility to virus infections of the skin, especially infections with herpes simplex virus and vaccinia virus. The eruptions caused by these viruses may be localized or generalized. In infants the generalized skin virus infections with herpes simplex or vaccinia virus can cause severe sickness and occasionally even death. In adolescents and adults fatalities appear to be extremely rare but severe temporary illness may ensue.

A VERY rare complication of atopic dermatitis is the formation of cataracts, which some ophthalmologists feel can be differentiated from other types of cataracts. In former years it was thought that these cataracts might be due to injudicious roentgen ray therapy, but it is now established that they occur in persons who never have had roentgen ray therapy.

Do emotional factors play an important role in producing or contributing to atopic dermatitis? There has been much fantastic conjecture about this but no reasonably scientific acceptable evidence. Emotional factors play a contributory role, but to no greater degree than many other factors in the body and its environment which are capable of influencing the disturbed vascular, sweat and other functions which I have mentioned. Emotional factors also lower the itch threshold and therefore may aggravate any pruritic dermatitis. Obviously, it is unwarranted to single out any one factor such as the emotional one and attempt treatment exclusively or principally from the psychosomatic viewpoint. One might just as well attempt to treat such patients only by making them avoid rapid changes in temperature or by preventing them from sweating.

In the future perhaps much more attention will have to be paid to the effects which this annoying and disfiguring disease has on the psyche of patients in childhood, adolescence and early life, than on the effects of the psyche on this disease.

There are a number of other unfavorable factors which often influence atopic dermatitis. Among these are dusty environments and intercurrent nonfebrile infections, especially colds and sinusitis. Febrile diseases, however, usually produce at least temporary improvement.

TREATMENT

THE management of atopic dermatitis should be tailored to the patient. A patient with a lichenified, slightly erythematous patch of atopic dermatitis in each cubital space deserves treatment of an entirely different nature than a patient with a severe extensive eruption which interferes with his sleep and his normal social and economic life.

In my experience, simple topical therapy, systemic antipruritic therapy with antihistamines or salicylates and avoidance of soaps is sufficient to clear the eruption in most mild cases or at least to keep it under control. In the more extensive and severe cases, however, a combination of therapeutic procedures and avoidance of known harmful factors should be prescribed. Even in very severe cases excellent results are often obtained with such combined management.

Suitable topical therapy is the single most important form of treatment in all cases of atopic dermatitis. Hydrocortisone preparations in the form of creams, ointments or lotions often are remarkably effective. Among the older remedies are antipruritic lotions containing menthol, phenol, coal tar solution and benzocaine and baths medicated with tar extracts or starch. The skin of patients with atopic dermatitis is notorious for its poor tolerance of greasy preparations (hydrocortisone ointments are an exception). Therefore one should prescribe baths, lotions and solutions rather than greasy ointments.

Often radiation therapy (with superficial roentgen rays and Grenz rays, which can be given in combination with topical therapy) is excellent for counteracting itching and lichenification.

Antihistamines by mouth often help to suppress itching. For the daytime it is preferable

to prescribe an antihistamine which does not induce much sleepiness (for example Teldrin [1]) and at night one which does tend to induce sleepiness (for example Phenergan [2]). Papaverine hydrochloride 0.1 Gram and aspirin, 3 to 4 times daily, also appear to lessen itching in some of these patients.

In view of all that has been said previously regarding the disturbances in sweating and the abnormalities in the regulation of skin temperature, vascular responses and cold pressure responses it is obvious that excessive heat, cold and humidity as well as rapid changes in temperature should be avoided insofar as possible. Patients with moderately severe or severe atopic dermatitis should be advised not to engage in activities which produce sweating, such as athletics. Contact with persons who have herpes simplex or active cowpox vaccinations must be avoided.

In patients in whom careful tests of avoidance and re-exposure—not just positive skin tests—have shown one or more allergens which contribute to the eruption such allergens should be carefully avoided.

Hospitalization and removal to another climate often bring about remarkable improvement even in otherwise treatment-resistant cases. At times, just removing the patient from his own apartment to an adjoining one is sufficient. Warm, dry, non-humid climates on the whole have been most beneficial to these patients.

The systemic use of corticotropin or corticosteroids is a more practical form of treatment in cases which are severe and which resist other therapeutic approaches. Occasionally I prescribe these agents also to tide a patient over an exacerbation which is likely to subside in one to three weeks. In the few exceptional cases in which hormonal therapy has to be administered over a long time, it has been my experience that often the dosage can be lowered gradually and that in some cases eventually this form of treatment can be stopped while other measures are continued.

Patients with atopic dermatitis should avoid dusty environments. Due to their alkalinity soaps are poorly tolerated. Instead, the patient should use soapless detergent bars or (if these are not available) liquid soapless detergents. Emotional tension should be eased insofar as this is feasible. Obviously an adolescent with severe itching who is under emotional strain because of a forthcoming school examination, is likely to have increased itch susceptibility and consequently will scratch more and worsen his eruption.

In summary then one cannot speak of a single causal mechanism in atopic dermatitis. It is not justified, on the basis of present knowledge, to conclude that it is an allergic dermatosis. It is still less justified to consider it a disease of emotional origin, since there is no evidence that emotional tension plays a more significant role than the many other important factors which influence the eruption. In most patients the use of a combination of relatively simple measures suffices to produce relief or completely clear the eruption. Moreover, in only a small proportion of patients does atopic dermatitis continue beyond the early twenties. Atopic dermatitis generally has an excellent prognosis if the therapist abandons parochial attitudes regarding etiology and manages the patient by a combination of suitable approaches.

1. Tradename, Smith, Kline & French Laboratories.
2. Tradename, Wyeth Laboratories.

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Incarcerated Appendices Epiploicae

A case of incarceration of two appendices epiploicae in a left direct inguinal hernial sac is described. This represents the thirtieth such case ever reported.

Projecting from the serous coat of the large intestine are many small processes known as the appendices epiploicae. Lesions of these processes sometimes cause acute symptoms necessitating operative intervention. An unusual case of an epiploic appendix incarcerated in a hernial sac forms the basis of this report.

So far as I have been able to ascertain only 29 such cases have ever been reported. Klingstein [1] in 1924 assembled ten cases of intra-hernial torsion and thirteen of intra-hernial strangulation of appendices epiploicae. Klingstein himself added two cases to this scant list. Since then four more have been cited.[2] My case, here reported, is the 30th.

A 44-year old man developed a tender, nonreducible bulge in the left groin. There were no accompanying gastro-intestinal or constitutional symptoms. He had a history of a "left inguinal bulge" of 13 years' duration which was always reducible. He then entered the hospital, where I found a 7 centimeter nonreducible, slightly tender, firm oval bulge with no perceptible impulse on coughing in the left groin. A complete blood count was normal.

Under spinal anesthesia, a left inguinal incision was made. A 5 centimeter blue, oval mass protruded through a 3 centimeter defect in the floor of the inguinal canal at a point midway between the internal inguinal ring and the pubic tubercle. The sac contained two dark red-blue fatty structures attached to the sigmoid colon. These appendages were resected at the base of their attachment to the colon. The floor of the inguinal canal was reconstructed by approximating transversalis fascia to the shelving border of Poupart's ligament.

The microscopic picture of the appendices epiploicae demonstrated extravasated blood with a few thrombosed blood vessels, consistent with a diagnosis of early infarction.

The appendices epiploicae of the sigmoid colon have a propensity for finding their way into left hernial sacs. This is because of the mobility of the sigmoid colon and the larger appendages attached to it. The incidence of pathologic involvement is about equal in males and females. However, inguinal herniae are more frequently involved in males and femoral herniae in females.

I have previously [3] discussed in some detail the causes of torsion of appendices epiploicae. Only occasionally is the actual twist demonstrated at the operation. Incarceration, with its attendant symptoms of pain and occasional signs of large intestinal obstruction, is likely to attract surgical intervention within twenty-four hours after onset. The condition is easily remedied by extirpating the infarcted or necrotic appendages.

1. Klingstein, P.: Surgery, Gynecology and Obstetrics, 38:376. (February 1924)

2. Moore, D. A.: New England Journal of Medicine, 222:919 (Dec. 1940); *also* Ladin, P.: New York State Journal of Medicine, 49:2168 (November 1949); *also* Ross, J. A.: British Journal of Surgery, 37:464 (March 1950). A case was also cited by David Campbell and may be found in the paper by H. M. Giffin *et. al* in Archives of Surgery, 45:351 (February 1942)

3. Fieber, S. S. and Forman, J.: Archives of Surgery, 66:329 (March 1953)

642 Eagle Rock Avenue

Garfield Duncan, M.D.
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The Problem of Obesity*

Obesity is no laughing matter. The problem of getting the patient to lose weight is one that demands all the doctor's skill—technical and tactical. In this carefully reasoned monograph, Dr. Duncan shows one way of doing it.

Obesity is one of the greatest challenges encountered in the practice of medicine. It is the most common of the metabolic disorders and one which affects degenerative disorders unfavorably. It reduces life expectancy remarkably. Yet, it is preventable and curable. Despite this, little impression has been made on the overall problem of obesity. Preventive measures are ineffectively applied and correction of obesity is the exception rather than the rule. The obese person is blind to the dangers that confront him or her. They hear but do not heed the physician's advice. They permit their enthusiastic enjoyment of food to run away with their judgment. But, "sooner or later all must sit down to a banquet of consequences." Sounding alarms, such as I am doing now, has little effect on this problem. Somehow, overweight must be made to be unpopular and it would seem that to accomplish this, some medium which reaches the public on a large scale is essential. Regular medical check-ups provide an excellent starting point, but the proportion of overweight patients who have periodic examinations is pitifully small. A public health approach on a broad base is essential if real inroads on this serious menace are to be made. The drive to make overweight unpopular might be started in our high schools. Subtle Public Health programs judiciously applied *via* radio and television could go far in fostering unpopularity for obesity. If the Popeye comic can make children eat spinach, surely the adult can be influenced by propaganda along the same vein. To date, most progress against obesity must be credited to the efforts of insurance companies. They at least have opened our eyes. The fact that they have an axe to grind may reduce the impression made upon the public, however.

Before embarking on a campaign, it is well to survey the potentialities of the enemy. Obesity increases mortality and shortens life expectancy. It is associated with higher incidence of certain diseases notably diabetes, essential hypertension, cardiac disease, diseases of the gall bladder and atherosclerosis. Furthermore, obesity affects unfavorably the prognosis in pregnant patients and in patients requiring major surgery.

The degree of compromise of health and longevity is in direct proportion to the degree of obesity. Obese diabetics for instance have a death rate 2½ times that of normal. But if the degree of overweight exceeds 25 per cent, the mortality, in these patients, is 8 times that normally expected. One in every five adults in the United States is overweight. Approximately 5 million persons weigh 20 per cent above their ideal weights.

It is difficult to get obese patients to reduce an appreciable amount of weight. More than

*Presented before The Medical Society of New Jersey, April 20, 1955, Section on Metabolism.

half who do have, within one year, regained much of what was lost.

FUNDAMENTALLY obesity results from a positive energy balance. More food is eaten than is necessary to maintain a normal weight. Why does the patient destined to be overweight develop this positive energy balance? Experimental work suggests a dulled appetite center in the hypothalamic area. Other findings suggest that metabolic, or neurosomatic, or psychosomatic disorders or some combination of these influences pre-determine the positive energy state and hence lead to obesity. Until more specific and practical information concerning these etiologic factors is known, it suffices to deal with them in general terms. For practical purposes we must return to reality and work with the agents at hand to cope with obesity.

The treatment for obesity must be as highly individualized as the treatment for diabetes. It is not always wise to reduce the obese patient immediately. If reparative processes are in operation, as in the case of a myocardial infarction, or during the recovery from infectious hepatitis or from an active tuberculous lesion, it may not be well to subject the obese patient to undernutrition at such times. One patient may reduce at a satisfactory rate on 1800 calories per day. Yet a diet as low as 1000 calories or even less may be necessary to achieve the same rate of reduction in another patient. This is due largely to the relative differences in economy of effort. Some obese patients have a great affinity for retaining salt and water. In such cases a temporary restriction in sodium intake is clinically helpful. The physically active patient can be given a more liberal diet than would be necessary in a hospitalized patient. For the obese patient who has led a sedentary life it is unwise to increase suddenly the amount of active physical exercise. That practice ordinarily would carry little risk in dealing with an active laborer.

HOSPITALIZATION

HOSPITALIZATION is essential if a satisfactory long term result is to be achieved. The advantages of having the patient in the hospital are:

(a) Close observation and all that this entails, including supervision of the diet and any special studies that may be desired.

(b) A complete break from home environment, responsibilities, and dietary habits is achieved.

(c) Proof that a loss in weight, and at a satisfactory rate, is possible despite patient's former belief, or claim, to the contrary.

(d) Instruction in diet when given to the patient by a dietitian skilled in this form of training and given on several occasions has been, in my experience, successful when instruction of the patient in the physician's office was futile.

(e) The impression which the patient receives concerning the nature of the disorder, its hazards, the unfavorable outlook and the means whereby the ground gained can be maintained is more effective than is otherwise possible for most of these patients.

These advantages proved to be so valuable that in recent years I have refused to treat obese patients, with rare exceptions, unless they submit to 7 to 14 days of supervision and training in the hospital. The seriousness of the disorder may be compared with the light hazards that attend an appendectomy or an attack of pneumonia for which there is no hesitation in seeking treatment in a hospital.

DIET

DURING the period of hospitalization with no prescribed physical activity, in an illustrative regimen, the *total calories* are reduced to 1000—the *protein* content to 100 Grams, the *carbohydrate* to 100 Grams, and the *fat* to 22 Grams. Restriction of salt intake is practiced in edema, myocardial embarrassment, arterial hypertension, and in patients who, judging from the history, are prone to retain salt and water to excess. One pint of skimmed milk and supplementary vitamins are given daily during the reduction campaign.

As increases in the diet become permissible the tendency is to add first to the protein until

this allowance reaches 125 Grams. Suitable upward adjustments are made in the total calories until the permanent diet is reached—that is, the diet which maintains a relatively constant body weight at the desired level. An illustrative diet might be approximately 125 Grams of protein, 300 of carbohydrate, and 33 of fat (2000 calories). The high satiety value of the liberal protein allowance is of special value. Small between-meal and bed-time nourishments often prevent the development of an excessive appetite. Restriction of the salt if observed is abandoned after the first few weeks of reduction unless specific need for it exists.

A rapid reduction in weight may be accomplished by limiting the caloric intake to 500 calories as suggested by Evans and Strang. A sample diet prescription is 70 Grams of protein, 40 of carbohydrate, and fat (to make up the balance) 6 to 10 Grams. This diet is surprisingly well tolerated when the patient is at bed rest, and in a hospital, and when mineral and vitamin deficiencies are guarded against. The absence of a craving for food when these low diets are employed illustrates the advantages that can be gained from the anorexia of severe undernutrition. Actually I do not prescribe such low calorie diets except during hospitalization and in cases of extreme degrees of obesity when it seems desirable to achieve a great reduction quickly.

Recently I have had success with alternating low caloric and maintenance caloric diets for patients who do not adhere to a reducing regimen week after week. Diets of 1000 calories and 1800 calories were alternated at weekly intervals. This same plan has been used with the diets alternating at daily intervals. Psychologically this reducing program is very well received.

EXERCISES

Strenuous physical exercise is discouraged in the early stages of reduction, especially in the extremely obese. The appetite stimulating effect of exercise as well as the increase in the total metabolism which accompanies exercise are not desirable for the very obese until the reduction program is well under way. As the diet is increased exercise is stepped up proportionately.

As the weight approaches the desired level a long term plan of daily exercise is adopted. This feature will be highly individualized. Irregularities in exercise are inadvisable. A plan which incorporates the desired amount of exercise in each day's program is ideal, *e.g.*, "park the car 5 to 6 blocks from the office daily" can be used to integrate adequate exercise into each day's routine. The climbing of a grade, a hill, or steps may have an added advantage in some cases. It is often remarkable how liberal the diet may be when wise use is made of a regular program of exercise. On the other hand to use exercise as a reducing agent and then abandon it when a satisfactory reduction is achieved encourages a return of the obese state.

PSYCHOTHERAPY

Some patients may have a motive in remaining obese; thus, some husbands prefer overweight wives. Also, a wife may think that a husband who is not overweight reflects unfavorably on her as a cook. Pennsylvania "Dutch" people have a deeply ingrained belief that overweight means good health and prosperity. Others have such a disinteresting life that eating is their greatest pleasure. Certain neurotics seek relief from anxieties in eating. A careful psychiatric appraisal of each obese patient by an internist—not by a psychiatrist—is fruitful in a surprising number of patients in elaborating a plan for restoring a normal state of nutrition. Education, reassurance, and securing the patient's confidence are important basic preparations for a long term reduction program. The advantages of group therapy and competitive reducing are not to be belittled.

DRUGS

Amphetamine sulfate in doses of 2.5 to 5 milligrams, combined with a mild sedative before breakfast and before lunch may help in reducing the craving for food which the occa-

sional patient experiences. It apparently is harmless in these amounts. The anorexic effect of this drug wears off quickly. There seems to be some advantage in using it three days in each week rather than to give it continuously. The results of anorexic drugs have, in my experience, been disappointing.

Thyroid therapy is indicated only in bona fide cases of hypothyroidism. In patients with normal thyroid function, such therapy has no effect until the dose is so large that it provokes evidence of thyrotoxicosis. Unlike the increased metabolism from exercise which can be abruptly controlled by rest, that resulting from thyroid in large doses is not under such prompt control. Several weeks elapse before the effect of toxic doses of thyroid disappear. It would seem that the obese patient with a total metabolism far above normal, by virtue of his obesity, should not be subjected to a further increase in his total metabolism particularly in the early stages of reduction and especially by an agent the effect of which cannot be promptly controlled. This is a consideration of considerable importance in patients who are predisposed to disorders of the cardiovascular system.

Diuretics are of value in obese subjects with myocardial decompensation as is *digitalis*. They do not play a role in the correction of the obesity but, as they aid in securing clinical improvement in certain patients, they should be used to cope with complications as indicated.

SUMMARY

OBESITY is a complex problem in which many influences may be at work. By virtue of predisposition to other and serious disorders, it carries much more risk than is usually accorded to it. Treatment must follow a thorough evaluation of the various influences which may, singly or in combination, play a part in causing obesity. Treatment is a prolonged enterprise which must be closely supervised with suitable adjustments along the way. Patients who have become obese seem, for long periods, to lose the fine adjustment between the satisfaction of appetite and the actual nutritional need which the normal person possesses. Because of this the measures employed to correct the obesity must be continued in a modified form, for long periods, to prevent a recurrence of the obese state.

330 South 9th Street

Age 70: Peak Productivity for the M.D.?

Most physicians over age 65 remain important and necessary members of the health teams in their communities, according to a poll conducted by Schering Corporation.

A questionnaire sent to physicians over 65, the conventional age of retirement, reveals that: (1) eight of every ten are still in active practice; (2) that *most of them* see more than 40 patients a week; and (3) one of every four will handle all types of cases. Three of every four do not accept surgical cases.

Comments on the returns showed remarkable activity by some physicians well over 65. A Virginia practitioner wrote: "I am now 86 years old and treat 25 patients a week." Another told the poll-taker: "I have a larger practice at 67 years of age than at any time in my 40 years of practice." Still another made the amazing statement: "On December 24, 1955, I was 90 year old. I have been in practice 60 years. I treat 40 or more patients a week, although I no longer do any surgery."

Over-all results of the poll, published in Schering's *Medicine in the News*, showed that while many physicians restrict their activities after 65, general retirement at that age for the majority seems not only undesirable but impossible.

Announcements • • •

Arthritis Symposium

On Wednesday evening, February 29, Dr. Otto Steinbrocker, the distinguished New York rheumatologist, together with Dr. Caesar Ragan, the well-known New York pathologist, will lead a symposium on arthritis. Held at the Academy of Medicine (91 Lincoln Park) in Newark, the symposium starts at 8:45 p.m. This is under the auspices of the New Jersey Rheumatism Association and is co-sponsored by the Academy of Medicine.

Women's Medical Meeting in Chile

On March 6, the Pan American Medical Women's Alliance meets in Santiago, Chile. This offers an opportunity for women physicians to discover the South American way of doing things. Husbands are permitted but not required for women who attend this meeting. It is a chance to get in an educational program with side trips to Mexico or the Panama Canal. For details, air-mail a letter now to Dr. Eva Dodge at 2124 West Eleventh Street, Little Rock, Arkansas.

Lung Carcinoma Lecture

On Tuesday, February 28, Dr. Richard Overholt will talk on "Lung Carcinoma: Direct Approach to Shadow and Substance." Dr. Overholt is the well-known and distinguished Boston clinician. This lecture will be given at the Pollak Hospital for Chest Diseases, 100 Clifton Place, Jersey City. The lecture will begin promptly at 9 p.m. This is the 2nd Annual Selig Waksman Lecture under auspices of the New Jersey chapter of the American College of Chest Physicians.

Psychiatric Residencies Available

The Veterans Administration Hospital at Lyons, N. J. now has available a number of fully accredited 1, 2 or 3 year psychiatric residencies. In addition to ward responsibilities, the training program includes lectures, conferences and seminars under the direction of the Department of Psychiatry, New York Medical College, and offers intensive training, both intramurally and through rotation in special hospitals and clinics in the adjacent area. There is, in addition, a series of extensive guest lecturers as well as an Annual Institute at the hospital. Training may commence at any time. For further details write to Manager, VA Hospital, Lyons, N. J.

Cardiology Seminar

A compact course in "cardiology in practice" is scheduled for March 14, at the Essex House (1050 Broad Street) in Newark. Sponsored by the New Jersey Heart Association, this seminar has been programmed to meet the needs of the practitioner. Dr. Irving Page of Cleveland will moderate the discussion and Dr. Ben Castleman of Boston, as the seminar's pathologist, will have the last word. In addition to a down-to-earth discussion of "managing the cardiac" there will be a novel unfolding of two actual cases. Discussion leaders include Dr. Charles Brown of Jersey City, Dr. Edward Bland of Boston, Dr. Simon Dack of New York and Dr. Thomas Durant of Philadelphia. The program starts at 1 p.m. that Wednesday (March 14, 1956), and you are invited. Dr. John Kinczel of Trenton is chairman of the program committee, and Dr. Harrold A. Murray of Newark is president of the Association. Further details may be obtained from either of these officers.

Course in Pediatric Neurology

The State Department of Health has developed a course of five seminars in pediatric neurology which will be held in the Presbyterian Hospital, 27 South Ninth Street, Newark, at 1:30 p.m. on Wednesday afternoons, March 28, April 4, April 25, May 2, and May 9. Attendance is limited and the registration fee for the entire series is $10. Further details may be obtained from or enrollment may be effected through Dr. Walter L. Mitchell, 15 Roseville Avenue, Newark, N. J.

Allergy Course

On April 15, 1956 the American College of Allergists will begin its three-day intensive training course in allergy in New York City. Physicians interested in this may obtain details from Dr. Fred W. Wittich, 401 LaSalle Building, Minneapolis 2, Minn.

New Pediatric Society

Announcement is made of the establishment of the Pediatric Society of Central New Jersey. This is intended as an instrument of communication among all physicians interested in pediatrics. Dr. Charles Hendee Smith of New Brunswick has been elected President for 1956, and Dr. Andrew D. Hunt, Jr., of Flemington has been elected Secretary for this year. The first scientific meeting was held on January 19. Physicians interested in being apprised of the further activities of this society, should communicate with Dr. Andrew D. Hunt, Jr., Hunterdon Medical Center, Flemington.

New Psychiatric Organization

Dr. Theodore R. Robie of East Orange, N. J. has been named as secretary of a newly-launched organization, "The Eastern Psychiatric Research Association." Primary aim of this organization is to initiate, encourage, and stimulate psychiatric research. It will also coordinate public and private research activities and develop better channels for the interchange of scientific information in all fields of medicine.

First president of the Eastern Psychiatric Research Association is David Impastato of New York. Dr. Impastato had an article on electronic therapy in the October 1955 issue of this JOURNAL. Dr. Leo Alexander of Boston is the vice-president. Arrangements have been made for publication in *Diseases of the Nervous System* of the transactions of the organization. Further information may be secured from Dr. T. Robie at 676 Park Avenue in East Orange.

Dental Medicine Case History Service

The Dental Medicine Institute offers case histories in the broad field of dental medicine for 1956. These include original 35 mm. Kodachrome slides of the oral condition, pertinent laboratory findings, medical background, roentgenograms, histologic slides, photomicrographs, diagnostic criteria and whatever else may be indicated in each individual case. A loose leaf binder and matching Kodachrome slide box will be furnished each participant.

This monthly service began January 1953 and has met with outstanding success. During these three years it has provided 250 enthusiastic members with 38 practical and useful histories with 75 Kodachrome slides and valuable up-to-date information.

A few case histories are available for the preceding years. Due to the great demand for this service, it is recommended to subscribe at an early date for assured and immediate delivery.

For further information, air mail your inquiry to Mrs. C. Novembri, 2240 Channing Way, Berkeley 4, California.

County Society Reports • • •

Camden

The regular meeting of the *Camden County Medical Society* was held December 6, 1955 at the customary domain with Dr. A. Gumersall Pratt presiding.

Doctors Leon Boguslaw, Harold L. Coburn, J. A. Gillerlain, Stanley C. Leonberg, Jr., Edward M. Podgorski and John K. Thomas were introduced to the Society after taking the membership oath.

Dr. Arthur W. Wase was introduced by Dr. Samuel V. Geyer of the Program Committee. Dr. Wase, who is Associate Professor of Biochemistry at Hahnemann Medical College, presented an instructive lesson on "Radioactive Isotopes and Their Relation to Medical Practice."

Dr. Harold Barnshaw informed the membership of a proposed biographic work of the Society's century of presidents. This would be prepared jointly by Dr. Helen Schrack and the Woman's Auxiliary.

Dr. F. W. Durham gave an interim report on his investigation of Social Security.

FREDERICK W. DURHAM, M.D.
Reporter

Cumberland

The *Cumberland County Medical Society* held its regular meeting on December 13, 1955 at Richards Farm with Dr. Nicholas E. Marchione presiding.

The members favored Dr. Carl N. Ware's suggestion to carry libel and slander insurance and empowered Dr. Albert B. Kump to make arrangements. Dr. Ware prepared a press release voicing the group's opposition to special clinics and free-for-all programs in the distribution of Salk vaccine. The Society gave its approval after considerable discussion of the public relations implications.

Dr. Frank J. T. Aitken reported on the Civil Defense meeting recently held in Trenton, N. J. Dr. Alfred O. Davies volunteered to replace Dr. Kurt Hansen who wished to be relieved of his duties as the Society's representative for hospitalization insurance.

The following members were elected to serve on the nominating committee: Dr. Carl N. Ware, Dr. M. David Baxter, and Dr. H. Burton Walker. Dr. Milton T. Fineman and Dr. Edward J. Chmelewski were elected to active membership. Dr. John Hislop Yeaman was elected to associate membership by transfer from Philadelphia County.

The featured speaker for this meeting was Dr. William T. Fitts, Jr., Associate Professor of Surgery, University of Pennsylvania, who presented an excellent illustrated talk on "Problems in the Diagnosis of the Diseases of the Colon." After adjournment, a splendid meal was served.

PAUL K. AYARS, M.D.
Reporter

Hudson

Under the chairmanship of Dr. Sigmund C. Braunstein, the regular monthly meeting of *Hudson County Medical Society* was held at Jersey City Medical Center, on December 6, 1955. Dr. Braunstein briefly eulogized our late vice-president, Dr. Arthur P. Trewhella, who died suddenly on Monday, November 28, 1955. The Society stood in silent tribute to the memory of Dr. Trewhella.

Following a report of the Medical Economics Committee by its chairman, Dr. Samuel S. Schept, a discussion took place as to means of obtaining liability coverage for members confronted with serious difficulty in this regard. Dr. Ruoff, chairman of the Insurance Committee, advised deferment of further action for about another month, during which time, action on the part of The Medical Society of New Jersey is anticipated. Dr. Butler, president of the State Society reported that "some type of national coverage" is expected as a result of the action of the A.M.A. at its Clinical Meeting in Boston, December 2.

Dr. Butler reiterated the stated position of the State Society with reference to the Salk Vaccine Program: that its members administer the vaccine without charge to those unable to pay, but receive payment for this service from those who can afford to pay.

Guest speaker was Dr. Joseph H. Burchenal, Professor of Medicine, Cornell University Medical College; and Chief of Chemotherapy Service of Memorial Center, New York City. Dr. Burchenal discussed the "Present Status of Chemotherapy of Neoplastic Disease."

CHARLES A. LANDSHOF, M.D.
Reporter

Middlesex

The regular monthly meeting of the *Middlesex County Medical Society* at Roosevelt Hospital, Metuchen, was called to order December 21, 1955 by Dr. Joseph F. Sandella, the President.

Dr. Russel Elkington, Director of Metabolic Unit, University of Pennsylvania Hospital spoke on the management of acute renal failure. Of special interst was his discussion of the "artificial kidney" or dialysis machine.

Dr. B. F. Slobodien, chairman of the Judicial Medical Ethics Committee presented the applications for associate membership of Dr. Eugene Trachtenberg of Highland Park, sponsored by Dr. Steinman.

Doctors Thomas Steinberg and Paul Jennings were elected to full membership.

ALFRED J. BARBANO, M.D.
Reporter

Passaic

The regular monthly meeting of the *Passaic County Medical Society* was held on Tuesday, December 13, 1955 at 9:00 p.m. at the Medical Society Building. Dr. Joseph R. Jehl, the President, presided.

The following were elected to active membership: Dr. Borys A. Filipczak, Passaic; Dr. Edward G. Krall, Fair Lawn; Dr. Harold Lubin, North Haledon; Dr. Peter J. McDonnell, Paterson. Associate members elected: Dr. John A. Bollinger, Haledon; Dr. Salvatore J. Giannini, Passaic; Theodore L. Zahne, Paterson.

A communication presented by Dr. Ben Berner to the Welfare Council, at its November meeting, was read by him before the membership. This concerned a proposal to launch a rheumatic fever prevention program for the early recognition of streptococcal infection by means of bacteriologic identification. The Society voted to endorse this project.

Dr. Jehl then introduced the first speaker, Mr. Stanley J. Fioresi, District Manager of the Social Security Office, Paterson. He was followed by Louis S. Wegryn, M.D., a member of the New Jersey Legislative Committee, of Elizabeth, N.J. The topic of both speakers was "Social Security" and a question period followed each talk.

At the close of the program a collation was served at a table attractively arranged in keeping with the Holiday Season, by the hostess, Mrs. S. H. Pink, of the Woman's Auxiliary.

DAVID B. LEVINE, M.D.
Reporter

Salem

On December 16, 1955, Dr. Eugene Pashuk, President, opened the regular monthly meeting of the *Salem County Medical Society*. The entire meeting was given over to a discussion of business affairs, principally concerning poliomyelitis immunization and the revision of our Constitution.

Letters were received from Mercer and Morris County Societies asking for support of Drs. Moriconi and Bowers for office of Second Vice-President. A letter was read from J. J. Thomas Co. regarding liability and slander insurance. It was referred to the Executive Committee. Mr. Wm. L. Manze, principal of the Penns Grove High School wrote asking that doctors consider the high school's lack of insurance when sending bills to pupils injured in athletic contests.

Dr. Harold Mark requested information regarding fee schedules for trips at a distance. The following committee was appointed to set up a suggested fee schedule: Drs. Wilbert R. Staub, R. S. Seda-Morales and Harold Mark.

The Cancer Committee reported supplying $95 worth of supplies gratis to one patient.

Dr. Pashuk led a discussion on the revision of our Constitution. There were no major changes and a copy will be sent to all members.

The society voted to continue its present policy about poliomyelitis immunization; that is to provide and administer free vaccine for all who are unable to pay.

CHARLES E. GILPATRICK, M.D.
Reporter

Somerset

Dr. John L. Spaldo, President, presided at the meeting of the *Somerset County Medical Society* held December 8, 1955.

A plan for establishing a county fee schedule for services to clients of the Board of Child Welfare was approved.

Dr. G. Hyer discussed the possibility of changing our Annual Dinner and Annual Clambake dates from a Thursday to Saturday. It was agreed to do so, whenever possible.

Approval was granted to the Heart Association for their prophylaxis program to provide penicillin tablets to indigent patients on referral by local doctors.

Mr. Richard Nevin, Executive Officer of the state medical society was present at the meeting and spoke briefly to the members.

C. S. McKinley, M.D.
Reporter

N. J. Neuropsychiatric Association

At its December 21 (1955) meeting, the Association heard a series of papers on the effectiveness and limitations of chlorpromazine and rauwolfia therapy. The occasion was saddened by the sudden death of Dr. Crawford N. Baganz, a recent past-president, who suffered a fatal coronary thrombosis on his way to the meeting.

Elected for 1956 were: Dr. Evelyn Parker Ivey (Morristown) as president; Dr. Ira S. Ross (South Orange) as president-elect; Dr. Robert S. Garber (Princeton) as secretary; and Dr. William Furst (East Orange) as treasurer. The Trustees elected were Doctors William Boutelle, Floyd Fortuin, John Kelly, David McCreight, Robert Mearin and Leo Reznikoff.

IRA S. ROSS, M.D.
Reporter

Book Reviews • • •

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

The Physician and the Law. By Rowland H. Long. Pp. 284, New York, Appleton-Century-Crofts, Inc., 1955. ($5.75)

Medicolegal information for the physician is compiled in this brief, comprehensive book, in a fascinating manner. The purpose of the book is to afford the practicing physician some knowledge of the rules of law which govern the physician-patient relationship and to help the physician who has to appear as a witness. The legal responsibilities and medicolegal situation arising out of the practice of medicine in our increasingly complex society create many legal hazards against which the physician should be constantly on guard.

The glossary aids in understanding legal and insurance terms. There is a nine-page table of cases listed for those who wish to go deeper into the study of any particular situation.

GEORGE C. FREEMAN, M.D.

Fluoroscopy in Diagnostic Roentgenology. By Otto Deutschberger, M.D. Pp. 771. W. B. Saunders Co., Philadelphia, 1955. ($25.00)

Fluoroscopy has mushroomed in the last few years. ("Doctor, do you have a fluoroscope?" asks the anxious patient making his first appointment.) However, no comprehensive textbook has been at hand, and all information is scattered throughout the roentgenological literature. This manual of technic and evaluation will be welcomed by all who use fluoroscopy. Proper training and proper emphasis upon methods of use will always be necessary in this field.

Dr. Deutschberger discusses the mechanical, physical and physiologic basis of this diagnostic method. The inherent limitations and the really important factors for the clinical fluoroscopist in regard to intensity discrimination and visual acuity are brought out. The author also points out that, although x-ray equipment will never be fool-proof, radiation injuries are caused directly by ignorance or negligence or a combination of both on the part of the examiner. Unfortunately, the author treats of these important matters in a rather dull fashion; a more dramatic presentation might better alert the practitioner to the vital necessity of strict precautions and discipline.

The chapters on clinical considerations of chest and abdomen are the meat of the book. There is a methodical attention to the details of proper technical observation. Preceding the clinical evaluation lesions and deviations from normal are thoroughly analyzed in regard to localization, size, structure, density, number, shape, definition, configuration and influence on structures. Then, the author focuses on the various pathologic conditions interrelating them with the fluoroscopic observations. He shows that it is often possible to arrive at a gratifying differential diagnosis based upon fluoroscopic findings. He details fluoroscopic encephalogram studies which seem meaningless for differential diagnosis. On the other hand, fluoroscopy of the paranasal sinuses which is of value is not included in this book. Fluoroscopy of the gallbladder, urinary tracts and female genital organs with contrast-materials is adequately discussed, and this might lead to more use of fluoroscopy in these examinations in this country. There is a very thorough chapter on fluoroscopic localization of foreign bodies. An excellent bibliography follows each chapter making the widely scattered literature on fluoroscopy easily available. The photographs used are true fluoroscopic images. The experienced examiner will find some helpful hints in this text. For the less experienced it is an invaluable guide.

FREDERICK STRAUSS, M.D.

Aging: General Aspects. Edited by G. E. W. Wolstenholme and Margaret P. Cameron for the Ciba Foundation. Pp. 255. Boston, Little, Brown & Co., 1955. ($6.75)

Aging is the number one problem in medicine in the United States today. With the ever-improving methods of prolonging human life, the potential magnitude of this problem staggers the imagination. In *Aging: General Aspects* seventeen experts in geriatrics present their views on various facets of this subject, ranging from "Definition and Measurement of Senescence," and "The Pathologic Basis of Aging," to such specific topics as "Calcium Metabolism in Old Age," and "17-Ketosteroid Excretion in Aging Subjects." These formal presentations are followed by round table discussions of the material. The disadvantage of this method of presentation is that, while it offers much in the way of interesting and provocative ideas, there is neither time nor space to deal adequately with the implications thereof. There is sufficient, however, in terms of original thought, constructive approach, and results of significant research, to make this book well worth reading.

HARVEY BLUESTONE, M.D.

Basic Surgical Skills. Robert Tauber, M.D. Philadelphia 1955. Saunders. Pp. 76. ($3.65)

The finest points of suturing can never be learned from a book—no matter how lucid the diagrams or explicit the text. But Tauber offers nearly everything.

All the basic knots and technics are here, in a book that is thin and lies flat when you open it. Apparently the publisher has learned something about good closure. The spiral binding is much better than conventional stitching for a work of this sort.

What is detailed in 72 pages *can* be learned by doing, using the easily made training board suggested by the author. This makes it much easier to learn the ABC's of surgical method: hemostasia, ligatures, and suturing. Tauber's is more than a how-to-tie-it text. He tells when and where to use the knots. "The Z suture is used mostly for covering and burying a formation (for instance, an appendix stump) in the center."

Basic Surgical Skills is for the medical student what Laoureux' *Practical Method for Violin* is for the learning musician. Finger dexterity is vital, no matter how deep the soul of violinist or surgeon. What the learner has seen performed in the operating room he can review and practice at home. No more sweating and fumbling while the surgeon leers across the table!

An operation is no better than the closure. He who follows the step-by-step lessons detailed here will emerge a better craftsman: technically competent, at least.

PETER O. GARNER

Chlorpromazine and Mental Health. Editor not named. Philadelphia 1955. Lea and Febiger. Pp. 200. ($3.00)

The wheel has turned once more. After going through a period of treatment by drugs, psychiatry went through a phase of physiotherapy, diet and baths; then entered the stage of psychological therapy; and now we are back to drugs.

In June 1955, Smith, Kline and French, manufacturers of chlorpromazine, sponsored a conference on the usefulness of the drug in psychiatry. This is a transcript of that session. Apparently no one who considered chlorpromazine useless was participating in the seminar. So all the speakers praise the drug, some with the unbounded enthusiasm that has hitherto been reserved for another brand of medicine man.

The moderator set the tone by describing the pre-chlorpromazine period as "one in which the strained sophistries of psycho-analytic theory contended with the empiric pseudo-science of electric shock." (Take that, Sigmund! Take that, Theodore!). Most of the speakers had spectacular results with chlorpromazine, though in many cases the practical result was given as "making him a better hospital patient, causing less difficulty in management." One frank observer found that 31 (out of 88) patients were improved by chlorpromazine, but that 16 (out of 88) improved on placebos! When attendants made the evaluations on a simple behavior scale, it was found that 22 improved on the drug; and 18 got better on a placebo.

Another reported that in some categories, more than 69 per cent of the patients were able to leave the hospital after getting chlorpromazine. These categories were drug addictions and personality disorders. (Don't all of them leave the hospital anyway?). Of the organic syndromes, however, fewer than 19 per cent could leave the hospital; and fewer than 25 per cent of the schizophrenics got well enough to leave. Since the return-home rate for insulin alone is higher than that, one wonders why this is considered worth reporting. There was some agreement that chlorpromazine does not control depressions, though even here, a few enthusiasts were quite willing to give sedatives to over-depressed patients.

The long range effectiveness of this drug is still to be measured. But it obviously has wonderful effects on the doctors who are reporting on it.

HENRY A. DAVIDSON, M.D.

Cardiovascular Diseases — Mortality, Prevalence and Control. The Heart Disease Control Program of the United States Department of Health, Education and Welfare, Washington, D. C. 1955, Pp. 68.

Thirty-six statistical tables survey the status of cardiovascular diseases in this unexciting book. Explanatory notes precede each table. These contain a few noteworthy items. Thus 53 per cent of all deaths in this country are due to diseases of the heart, blood vessels and kidneys. They accounted for four times as many deaths as cancer. In this group, arteriosclerotic heart disease was the most important single cause. Second is hypertensive heart disease. Its mortality rate is almost twice as great among the non-white members of our population.

About a million persons in this country have rheumatic heart disease. This disease causes its greatest number of deaths in the 55 to 64 age group, although it first appears at a much earlier age.

The volume concludes by recommending heart disease control at the state level and outlines in some detail the clinics and heart disease detection programs in each state. Essentially, a book of tables and statistical data, this publication will appeal mostly to public health workers. The practicing physician or cardiologist will find it of little value.

R. D. GOODMAN, M.D.

Authors' Clinic . . .

A Spelling Lesson

The simplified spellings which have won general acceptance are used in this JOURNAL. The "e" replaces "ae" in words like precox, anesthesia, gynecology and previa. The "e" replaces an "oe" in words like orthopedics and esophagus. The "-or" ending (and not the "-our" ending) is used for words like labor, color and honor. The short "-et" suffix is really enough for cigaret and buret. However, we do not accept orthographic monstrosities like "nite" and "thru."

The following list gives enough examples to indicate the general practice. The word printed first is spelled properly. The word in parentheses represents the unacceptable form. Note that "k" is preferred to "ch" (as in "diadokokineses"), and at the end of a word, is used instead of "-c" as in "disk." As an initial letter, "c" is preferred to "k" ("catabolism").

adiadokokineses (adiadocho-)
ameba (amoeba)
ampule (ampoule)
anatomic (anatomical)
aneurysm (aneurism)
calory (calorie)
catabolism (katabolism)
cigaret (cigarette)
curet (curette)
defense (defence)
dilation (the process)
dilatation (the status)
disk (disc)
dram (drachm)
dulness (dullness)
exophthalmos (exophthalmus)
fantasy (phantasy)
fantom (imaginary)
phantom (a model)
fiber (fibre)
gage (gauge)
hiccup (hiccough)
histologic (histological)
intern (interne)
lacrimal (lachrymal)
leucocyte (leukocyte)
mold (mould)
pathologic (pathological)
pipet (pipette)
precox (praecox)
preventive (preventative)
previa (praevia)
sanatorium (sanitorium)
skeptical (sceptical)
skilful (skillful)
sulfur (sulphur)
technic (technique)
titer (titre)
vitamin (vitamine)
whisky (whiskey)

Attention is invited to the words ameba, ampule, anatomic, dulness, gage, lacrimal and technic. Editorial experience indicates that the unnecessary long form is especially common with words of this type.

The terminal "-al." Words like "psychologic," "pathologic" and "etiologic" are written that way and not "psychological or pathological." The rule is: if without the terminal "-al," the word has three or fewer syllables, add the "al," thus:

chemical	physical
clinical	statistical
musical	surgical
obstetrical	

However, if without the suffix the word already has four or more syllables, omit the terminal "-al," thus:

anatomic	periodic
etiologic	physiologic
gynecologic	psychiatric
neurologic	psychologic
otologic	serologic
pathologic	urologic

There is no more reason for "psychological" than there would be for "orthopedical"; and "pathological" is as valid as "cyanotical."

When in doubt, omit the terminal "-al."

Possessive form of names ending in "s." Add the apostrophe only; do not use a double "s." Examples: Colles' fracture, Graves' disease.

Plurals of Latin and Greek words. Medical English abounds in words borrowed without change from Latin or Greek (bacillus, fundus, protozoon, phenomenon, viscus, and the like). In many instances the English plural would be uneuphonious; this would be the case with words like "viscuses," "bacteriums," "criterions," "stratums," etc. Under these circumstances (and always when the word has not been thoroughly Anglicized) use the Latin or Greek plural. In the following list the foreign plural forms are given and should be used. In fact, the foreign form should be used for the plurals of all borrowed words except tumors and those in the short "List B" below.

List A. Retain foreign plurals as follows:

alveoli	humeri
antra	indices
apparatus	larvae
appendices	media
axillae	micra
bacteria	nuclei
condylomata	phenomena
criteria	polypi
curricula	protozoa
data	scotomata
desiderata	sequelae
emboli	sequestra
foci	sera
foramina	spermatozoa
fundi	stigmata
ganglia	uteri
gummata	vertebrae
hili	viscera

List B. Use English plurals as given for the following:

aortas	fetuses
axillas	fibulas
carcinomas	formulas
comedos	hernias
corneas	lipomas
craniums	patellas
enemas	retinas
epitheliomas	scleras
femurs	

When in doubt, retain the foreign plural, except for tumors ending in "-oma." In these cases, use English plurals (sarcomas, fibromas, osteomas, etc.).

HENRY A. DAVIDSON, M.D.

Obituaries • • •

DR. CRAWFORD N. BAGANZ

On December 21, 1955, Dr. Crawford N. Baganz, Manager of the VA Hospital at Lyons, N. J. died while en route to a medical meeting. Dr. Baganz was nationally known in the field of psychiatry. He had just been elected to the Council of the American Psychiatric Association and was due to start his service there in April. He was the founder and first secretary of the Board which certifies mental hospital administrators. Dr. Baganz was also the prime mover in the development of local branches of the American Psychiatric Association and was the first Speaker of the Assembly of Branches.

Born in Terre Haute, Indiana in 1905, he was graduated in 1930 from the medical school of the university in Indianapolis. He entered the Veterans Administration in 1932 as a ward officer at Lyons, N. J. He then became chief of the psychiatric service at the VA Hospital in Topeka, Kansas. From there he transferred to the VA Hospital at North Little Rock, Arkansas, where he was director of professional education. He became professor, and head of the department of psychiatry at the University of Arkansas.

During World War II he served in the Navy. He then returned to New Jersey, this time as Manager of the VA Hospital at Lyons, where—20 years before—he had started his VA career as a ward physician. He had been one of the founders of the New Jersey Neuropsychiatric Association and shortly after his return to New Jersey became its president. He also recently became professor of clinical psychiatry at the New York Medical College. Dr. Baganz was a diplomate of and an examiner for the American Board of Examiners in Psychiatry and Neurology.

At the time of his death, Lyons was planning to develop, in affiliation with Rutgers University, a course in training of hospital administrators — a program which resulted largely from Dr. Baganz's own work in organizing the Board for the certification of administrators.

DR. JACOB GOELLER

Dr. Jacob Goeller died January 3, 1956 at the age of 58. A native of Newark, Dr. Goeller received his M.D. degree in 1922 from Cornell Medical School. After interning at the Martland Medical Center in Newark, he became interested in anesthesiology, eventually becoming anesthesiologist at the Irvington General, consulting anesthesiologist at the Clara Maass and chief of the anesthesiology section at the Martland Medical Center. Dr. Goeller was a Fellow of the American Society of Anesthesiologists. During the war, Dr. Goeller was a major in the medical corps. He was active in civic and religious organizations in the Irvington area.

DR. MORRIS GROSSMAN

A long-time leader in neurologic rehabilitation, Dr. Morris Grossman died December 28 (1955) at his Jersey City home. Born in Hungary in 1881, Dr. Grossman came to New York in infancy. He was graduated from Fordham's medical school in 1909, and after some years of graduate study in neurology went into private practice in New York. He did pioneer work in neurologic rehabilitation and helped develop the neurologic clinic at New York Mt. Sinai Hospital. Eventually he became chief of that clinic. For many years, Dr. Grossman maintained a summer home at Long Branch, N. J. and was a widely called neurologic consultant at the Monmouth Memorial Hospital there. At the age of 60, having reached the retirement age for Mt. Sinai clinic physicians, Dr. Grossman transferred his practice to New Jersey and carved out a new career in neurology in Jersey City, from 1942 to 1955.

DR. WILLIAM L. HARRINGTON

The dean of East Orange medicine is dead. Dr. William L. Harrington died on December 20, 1955 while visiting the nurses' home at the East Orange General Hospital to wish them all a merry Christmas. Born in upstate New York in 1884, he was graduated from the New York Medical College in 1907. After an internship in New York and some graduate work in obstetrics there he came to East Orange in 1910, and remained in that city until his death in 1955. Dr. Harrington was active in civic affairs, having served as medical director of the East Orange schools, as chief surgeon to the city Fire Department, as a charter member of the East Orange Kiwanis Club, and as Senior City Physician. Dr. Harrington rose through the ranks at East Orange General Hospital, serving for years as Chief of the Obstetrical Service and later as Chief of Staff of that hospital. He was active in the Essex County Medical Society, the New Jersey Obstetrical and Gynecologic Society and the local Academy of Medicine.

DR. HENRY E. RICKETTS

Old-timers in northern New Jersey will remember the many pioneering contributions of Henry Ricketts to the public health aspects of medical practice. From 1908 to 1922 he was the superintendent of the state's largest contagious disease installation —the Essex County Isolation Hospital at Belleville. Under his leadership, Soho expanded from an old-fashioned "pest house" to a modern hospital.

Born in Poughkeepsie in 1877, Henry Ricketts was graduated from the College of Physicians and Surgeons (Columbia University) in 1905. After an internship in New York City, he went to the famous Kingston Avenue Hospital—said to be the largest isolation hospital in the world—in Brooklyn and from 1906 to 1908 served a residency in contagious diseases. The Essex County Freeholders then invited him to head up the expanding program at Soho, and at the age of 31, he became superintendent of that institution.

After retiring from the Soho superintendency, Dr. Ricketts served as a medical consultant to the Newark schools and was later in private practice. Dr. Ricketts died on December 22, 1955.

DR. CHARLES W. WILSON

At the grand old age of 89, Dr. Charles W. Wilson of Vineland died on December 3, 1955. A graduate of Jefferson Medical College, class of 1890, Dr. Wilson came to Vineland in 1891 as a staff physician to the Training School. The following year he opened an office for part-time private practice. In 1900 he became staff physician to the New Jersey Home for Disabled Veterans.

Dr. Wilson was active in the Masonic order, as well as in numerous civic affairs.

DR. A. CHARLES ZEHNDER

Dr. A. Charles Zehnder, a life-long resident of Newark, died at the age of 74 on December 1, 1955. Graduated from the Cornell University College of Medicine in 1907, he did general practice in Newark until 1917 when he was commissioned in the medical corps of the Army. Demobilized as a captain, he returned to private practice, devoting increasing attention to, and eventually specializing in ophthalmology. He was active in the Essex County Medical Society, serving in numerous offices, becoming president of that component in 1944. Dr. Zehnder was the senior ophthalmic surgeon at the Newark Eye and Ear Infirmary, attending ophthalmologist at St. James Hospital in Newark, and consulting ophthalmologist at Mountainside Hospital in Montclair.

TUBERCULOSIS *Abstracts*

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THE PRESERVATION OF LUNG TISSUE IN THE TREATMENT OF PULMONARY TUBERCULOSIS

By Col. James H. Forsee, MC, U. S. Army
Military Medicine, August, 1955.

The surgical removal of tuberculous lung tissue in the present era of chemotherapy has revolutionized the treatment of pulmonary tuberculosis. Its use by the Armed Forces Medical Services has been so unprecedentedly good that treatment for this disease is only a temporary interruption in the career of military personnel.

The case history of patient "A," is illustrative of many which are similar. Patient "A," age 46, had his left upper lobe removed and a five-rib thoracoplasty performed in October, 1951, at Fitzsimmons Army Hospital. He is well, returned to active duty in March, 1953, and has been on duty over a year. He states that he has no cough, pain or chest discomfort and maintains his normal weight. Frequent examinations give no evidence of reactivation of the disease and sputum and gastric washings are negative for M. tuberculosis.

He became ill in March, 1951, and in April the diagnosis of pulmonary tuberculosis was confirmed by the isolation of M. tuberculosis from the sputum. A 3 cm. cavity was demonstrated on roentgenographic examination. Hospitalization and streptomycin, 1 gram every third day and para-aminosalicylic acid, 12 grams daily, were started. Six months later there had been appreciable clinical improvement, a small cavity remained, and excisional surgery was done. At operation, the upper lobe contained numerous smaller nodules in addition to the cavity. In the lower lobe there were scattered nodular areas. To remove the visible and palpable tuberculous disease would have resulted in the loss of the entire lung and conservation of the lower lobe seemed feasible. Decreasing the size of the hemithorax by a five-rib thoracoplasty helped to prevent over distention of the remaining lobe and probably decreased the danger of reactivation of latent lesions. No visible deformity results from upper lobectomy and a five-rib thoracoplasty.

Preserving involved lung tissue without increasing the risk of disease activation is now being achieved largely through the use of streptomycin and other chemotherapeutic agents. These agents are effective in bringing about the resolution of recently developed, exudative lesions and in localizing the lesions which do not resolve. Moreover the protracted use of these drugs favorably influences the stabilization of tuberculous lesions, increasing their suitability for surgical extirpation. The amount of lung tissue needing removal is thereby decreased. The combination of certain chemotherapy agents has virtually eliminated the development of resistance to the drugs. Their use for extended periods following surgery has an additive effect of insuring permanency of inactivation of any remaining disease areas.

The removal of an entire lung has, in our experience, seldom been indicated. Pneumonectomy has been performed in less than five per cent of more than 900 tuberculous patients treated by excisional surgery since January 1, 1947. Usually the less involved lower lobe has been retained and only the more extensively involved upper lobe removed. Two hundred sixty-one patients were treated by lobectomy during the period 1947-

1952, and in the vast majority there was appreciable disease in the remaining lung tissue on the operated side. Ninety per cent of these patients are now well, and working or able to work. Pneumonectomy has been reserved for those patients who have a severe stenosis of the main stem bronchus which is usually associated with an extensively destroyed lung.

The retention of minimally involved segments of a lobe and removal of the more involved broncho-pulmonary segments of the lobe is greatly increasing the feasibility and practice of returning military personnel to active duty after being treated for tuberculosis. This increase is shown by the fact that while during 1947-49 only 25 patients were treated by segmental resection, since January 1, 1953, 185 patients have received this form of surgical therapy. In 75 per cent of the segmental resections, the apical and posterior portions of the upper lobe were removed. Segmental resection is strongly recommended for the removal of proved or suspected lesions which are unpredictable. This is far safer than permitting them to remain.

The surgical removal of residual foci by simple wedge excision also conserves lung tissue. Lesions suitable for wedge excision are usually situated peripherally and immediately subpleural. They represent either the residual foci of previously larger areas of disease or they may have been present and unchanged for months or years. None of the patients treated by wedge excision were classified as far advanced. If M. tuberculosis are demonstrated in the excised tissue, the patient is treated as having active tuberculosis including chemotherapy and bed rest. If the lesion is a granuloma of non-tuberculous etiology, a protracted period of hospital care is unnecessary.

The need for the surgical extirpation of these foci, is based on several factors. An appreciable percentage of roentgenographically similar lesions are neoplastic. One cannot predict accurately whether or not the specific organisms are contained in the given lesions. We know that small lesions become larger ones and minimal disease is often the fore-runner of a far advanced process. The meticulous study of a group of approximately 500 patients with minimal tuberculosis followed for a minimum of a five-year period revealed that 50 per cent suffered relapse. The surgical excision of these small lesions is feasible and practical and the mortality has been comparable to the removal of a diseased appendix.

There is strong evidence that the present increase in the incidence of surgical therapy will be continued and that there will be relatively few tuberculous patients who will not be benefited by proper surgery. The surgeon who successfully treats tuberculous patients properly employs the guidance of his associates and becomes a member of the tuberculosis therapy team which has replaced the one-man tuberculosis expert. In addition, the surgeon must painstakingly maintain follow-up studies for a protracted period on each patient before final assessment of treatment.

Modern military medicine effectively utilizes the tuberculous therapy team. A few hospitals have been staffed with experts in their respective fields interested in the care of tuberculosis patients, including rehabilitation. With these facilities, those properly motivated are returning to duty. Most of the military personnel are able to resume active duty following hospitalization and rehabilitation.

In military service the plan of roentgenographic examination at frequent intervals, such as induction, annual physical examination, separation from the service, reenlistment, admission to hospital and prior to overseas assignments provides the opportunity for the early detection of pulmonary diseases and contributes greatly to the good results being obtained in the treatment of pulmonary tuberculosis in military personnel.

The results of a policy of conserving lung tissue in pulmonary tuberculosis have been almost phenomenal. Of 165 patients on whom follow-up studies of two and one-half years or more are available, three patients are dead; only one had active tuberculosis at the time of death. Data on two patients are inadequate. Of the remaining 160 surviving patients, 98.7 per cent are well, and working or able to work. Pulmonary tuberculosis in military personnel of the United States is now being detected early and is usually a readily manageable disease which only temporarily interrupts their careers.

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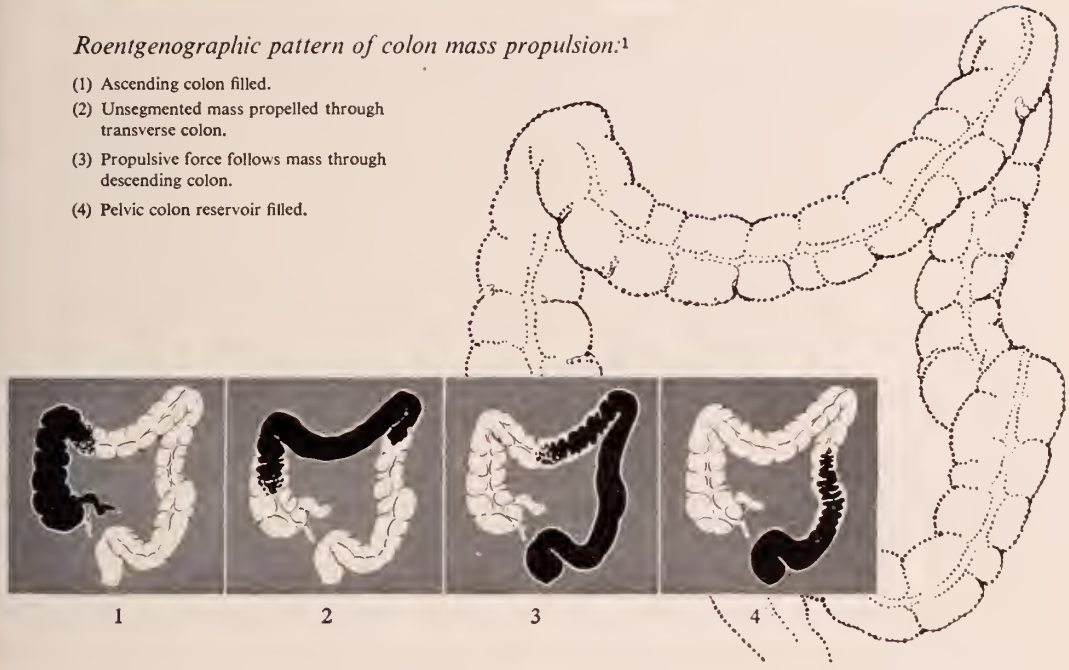
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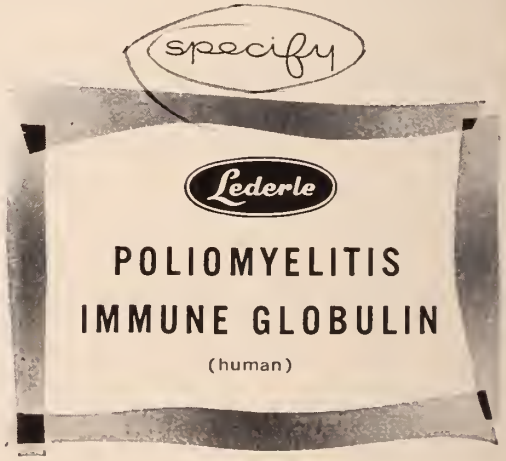
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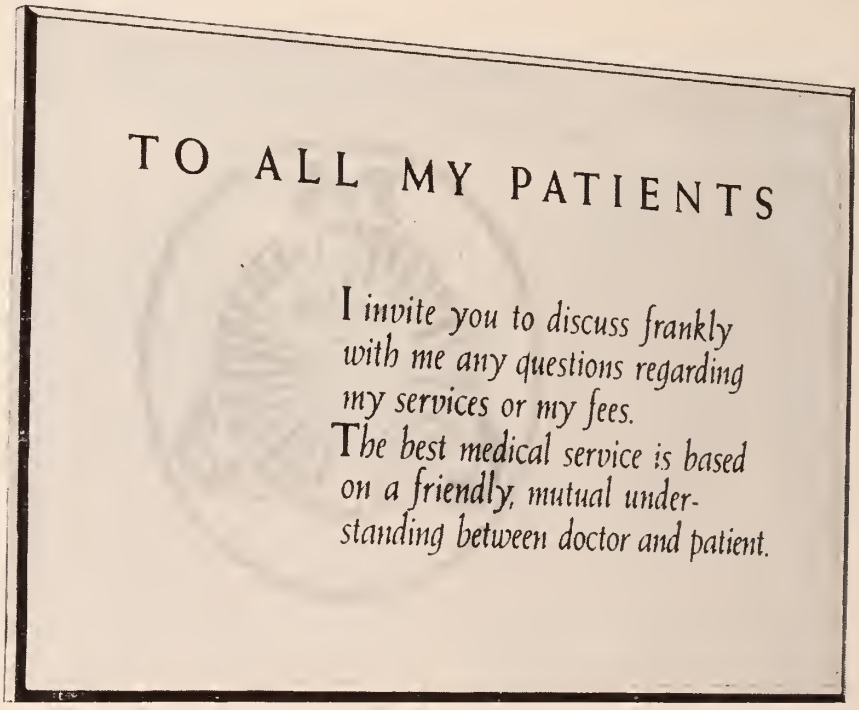
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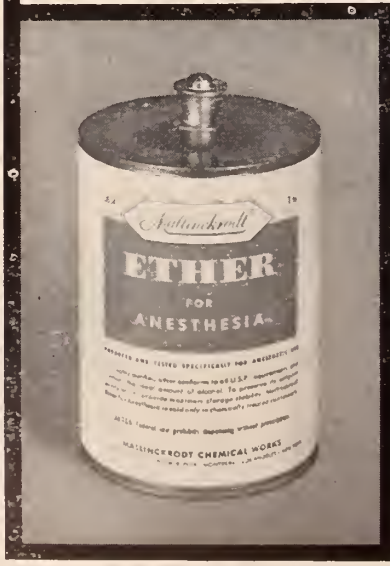
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1. Rosenberg, S. and Oster, K. A., "Gelatine in the Treatment of Brittle Nails," *Conn. State Med. J.* 19:171-179, March 1955.
2. Tyson, T. L., *J. Invest. Dermat.* 14:323, May 1950.

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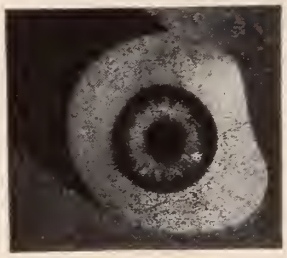
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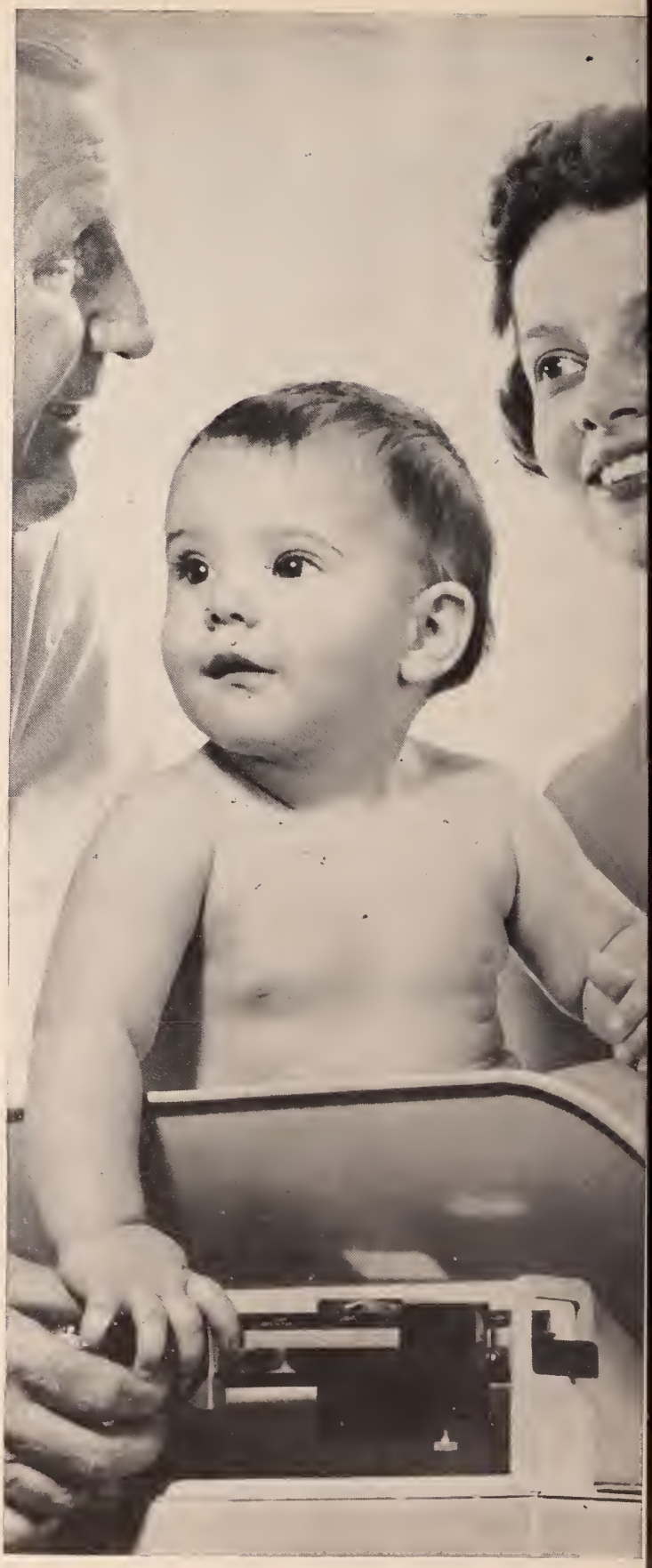
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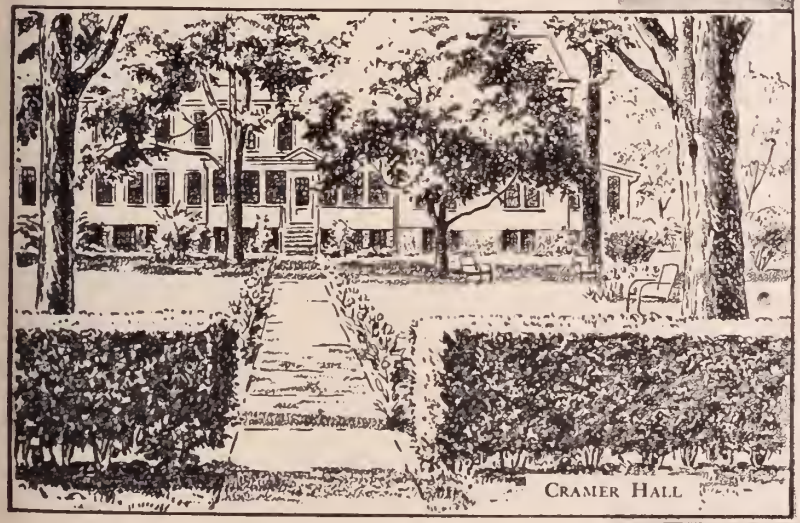
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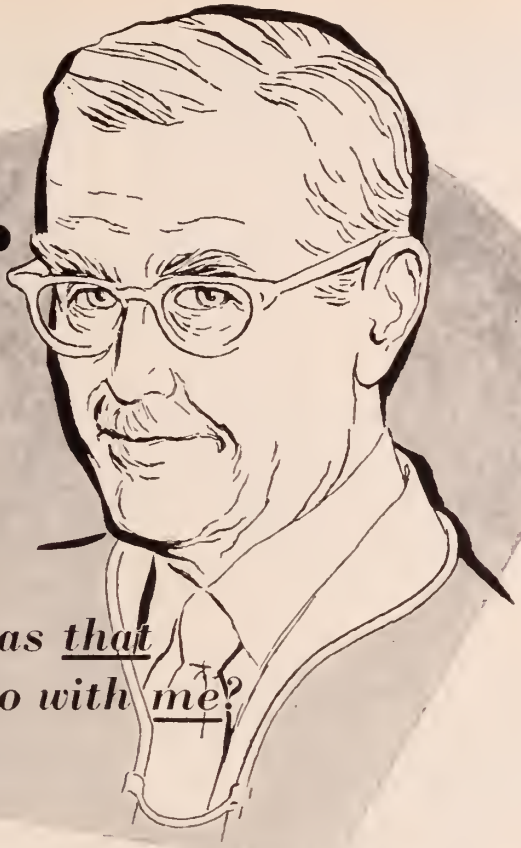
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Benzedrine* Sulfate (racemic amphetamine sulfate, S.K.F.)	2.5 mg.
Aspirin	2.5 gr.
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1. Medical Gynecology, ed. 2, Philadelphia, 1950 *T.M. Reg. U.S. Pat. Off.

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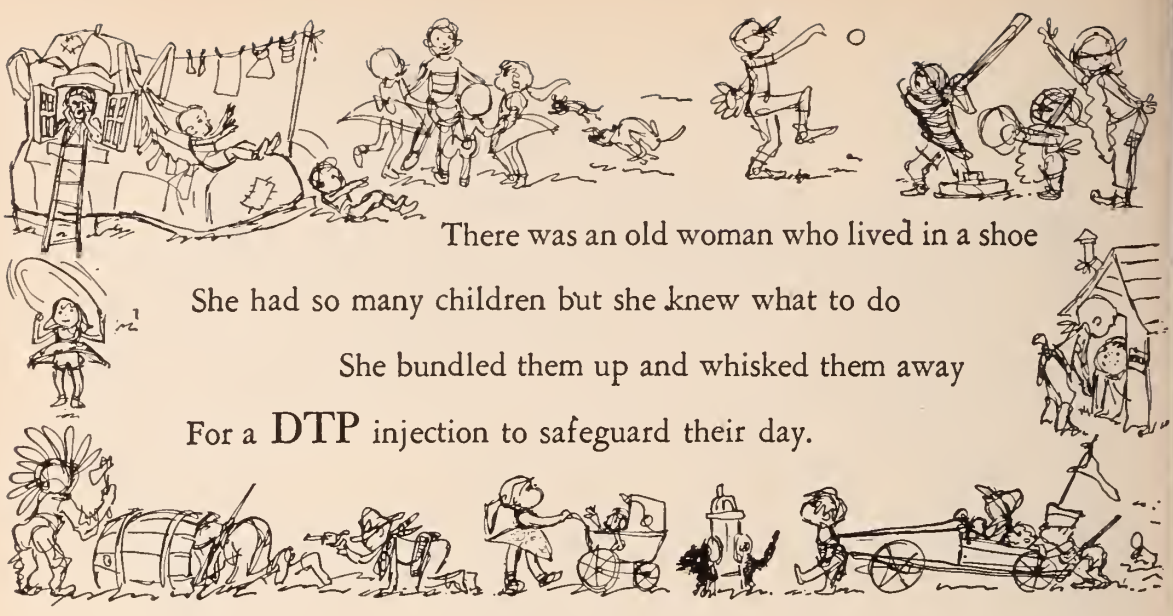
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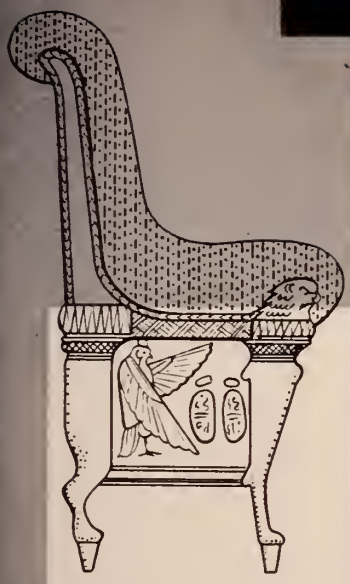
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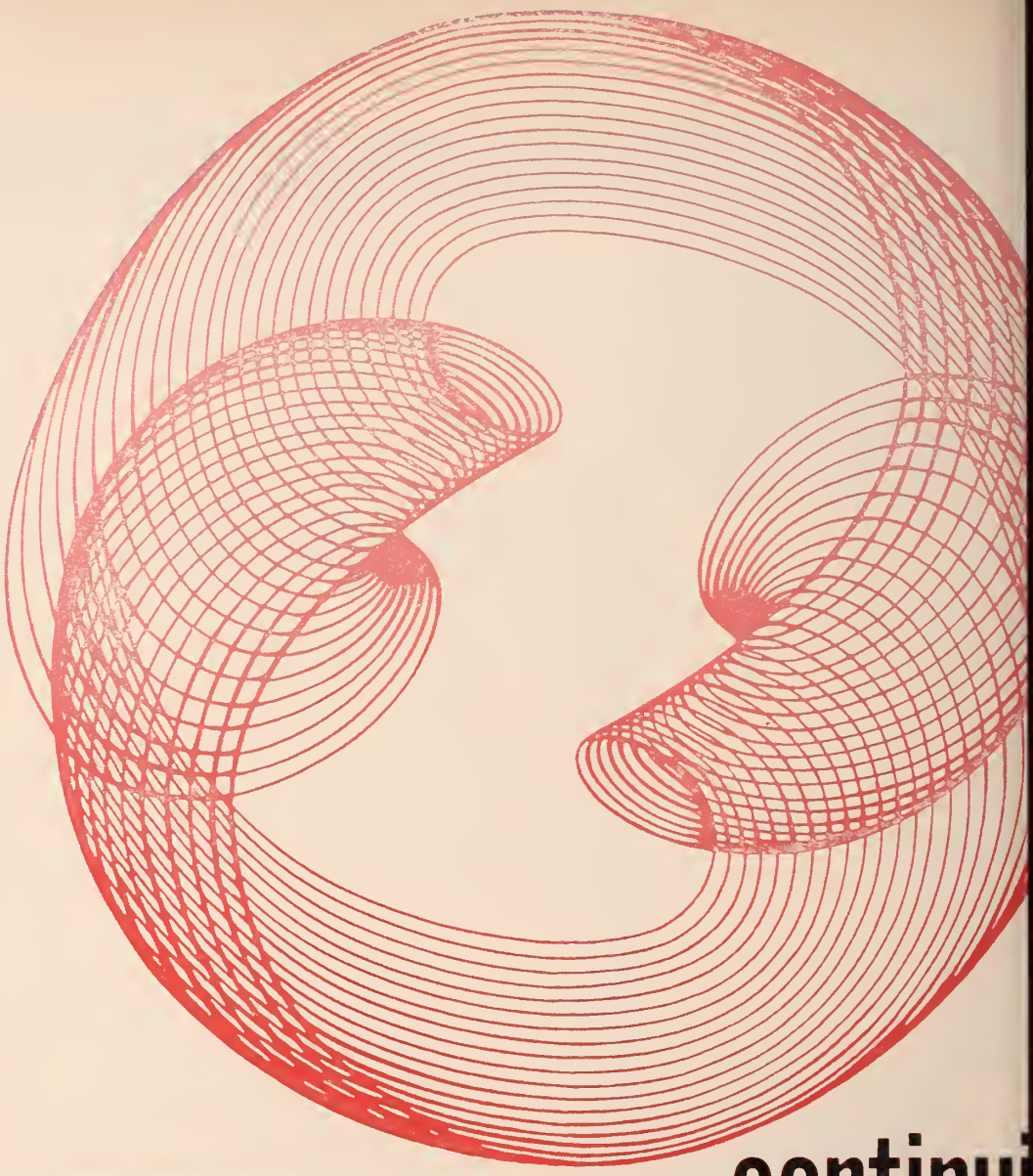
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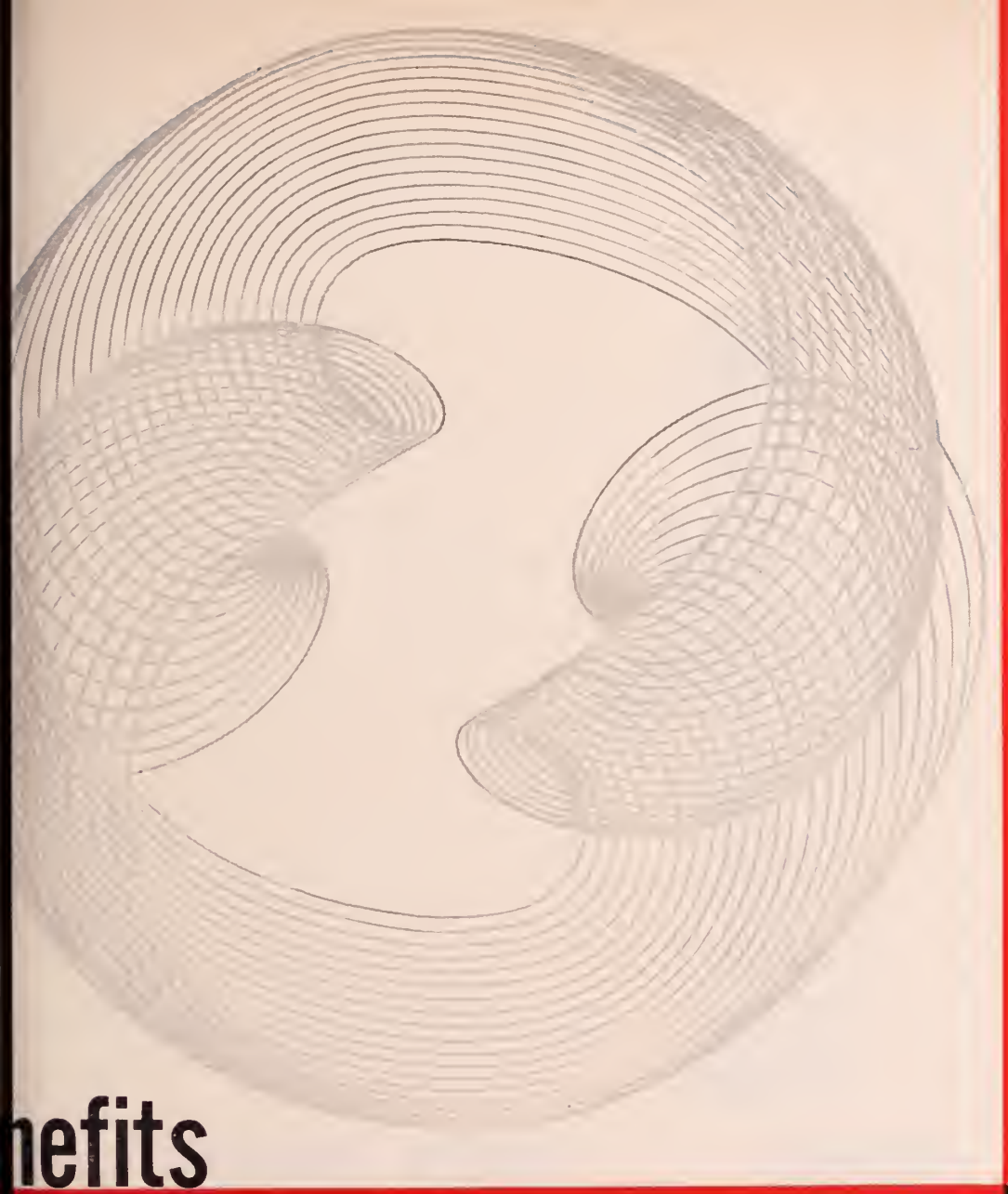
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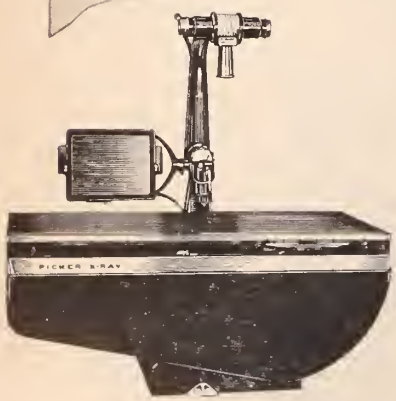
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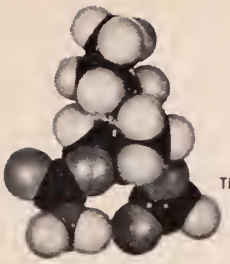
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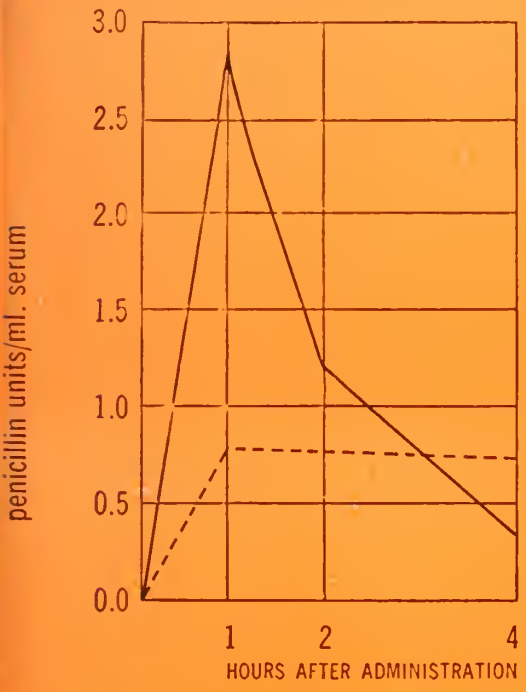
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1. Wright, W.W.: Personal communication.
2. Price, A.H.: Personal communication.

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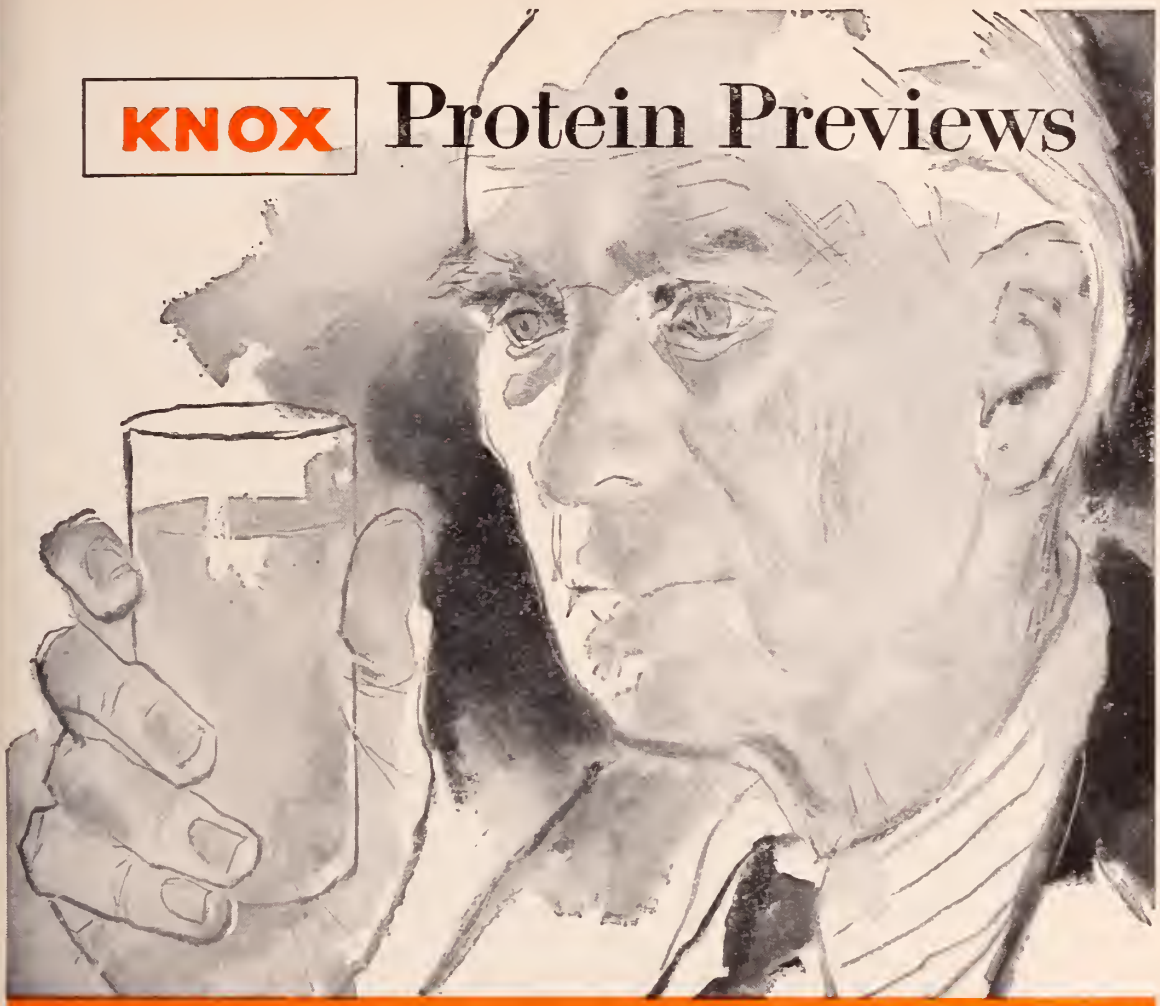
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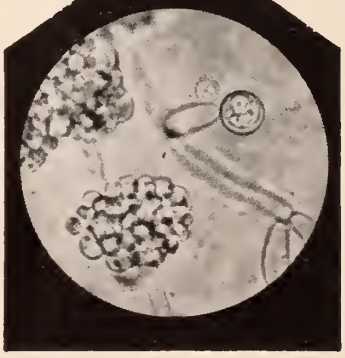
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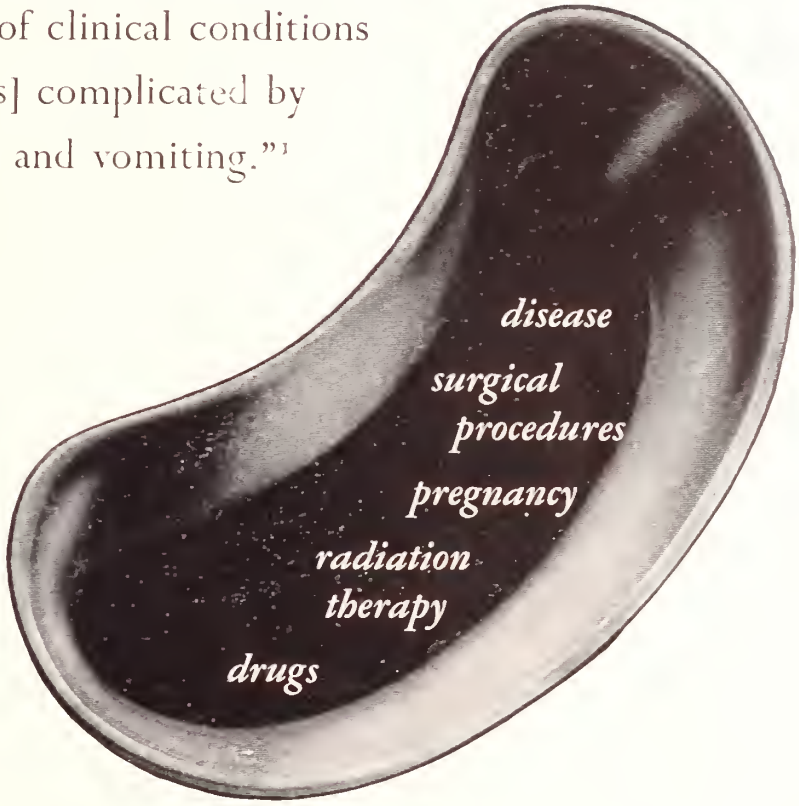
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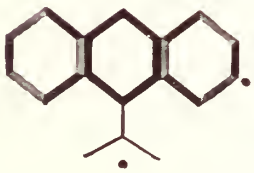
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1. Moyer, J.H., et al.: Arch. Int. Med. 95:202 (Feb.) 1955.

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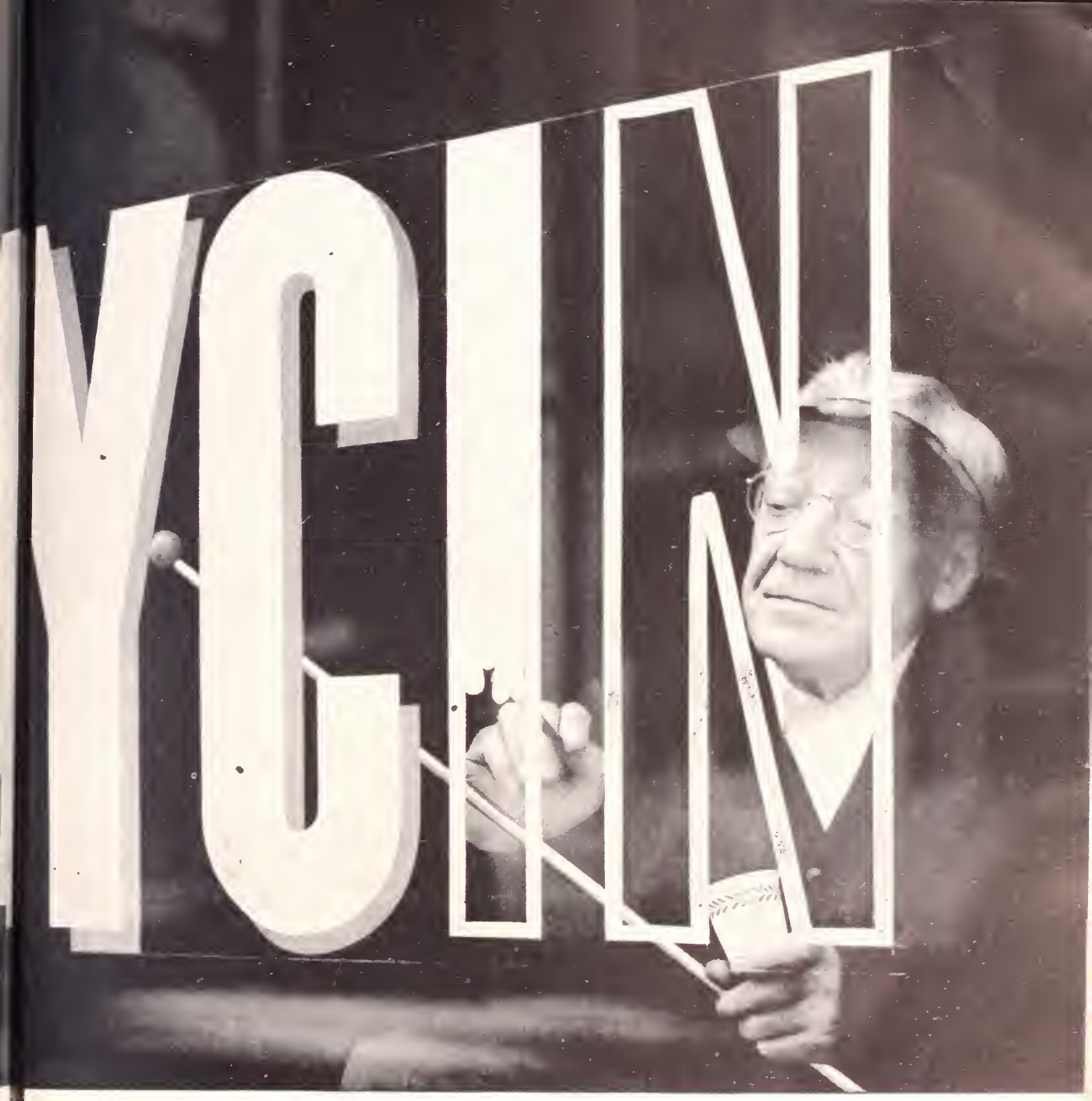
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Erythromycin in treatment of pyoderma

8/12/55

DISCHARGE SUMMARY

Patient, white female, age 39, entered hospital with a diagnosis of lymphoma, proved to be lymphosarcoma by biopsy.

Initially she was treated by X-ray radiation, adrenal cortical hormone and an antinauseant. During this regimen she developed a generalized rash which became infected. This was a drug reaction with infection due either to (1) scratching or (2) a low WBC count due to radiation. A number of boil-like lesions appeared over the body.

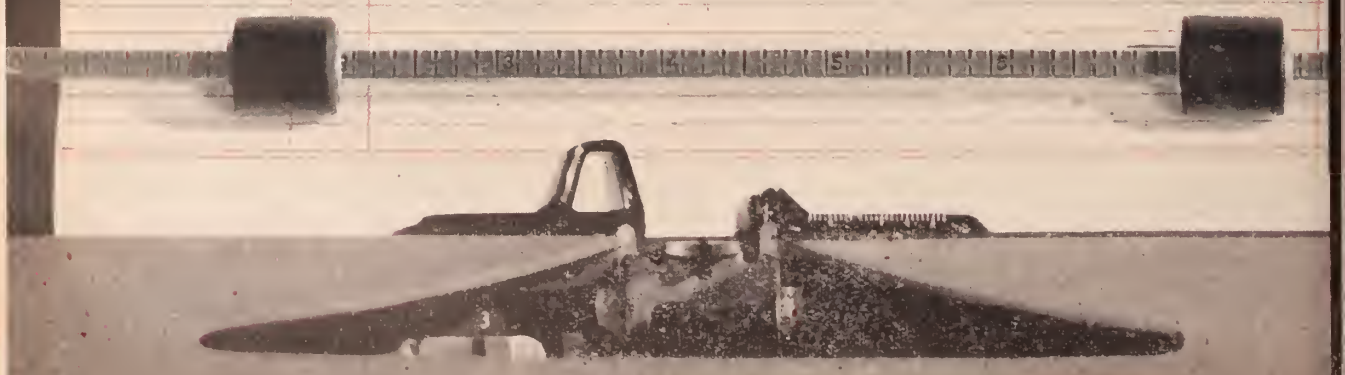
On 8/4 penicillin was started in a dosage of 600,000 units daily. Penicillin was continued for six days during which time the pyoderma became worse.

Aspirated material from the lesions yielded hem. S. aureus, coag. + and the following sensitivities were obtained: penicillin, more than 10 units; erythromycin, 10 mcg.; tetracycline, 50 mcg. When these results became available penicillin was discontinued.

On 8/9, erythromycin was started in a dosage of 200 mgm. q. i. d. Marked improvement was noted very soon and by 8/12 almost complete healing of all lesions had occurred. Patient was afebrile throughout.

Final Diagnosis: (1) lymphosarcoma (2) secondary pyoderma due to hemolytic Staphylococcus aureus.

Result: complete healing of secondary pyoderma with erythromycin.



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*Filmtab—Film sealed tablets; patent applied for.

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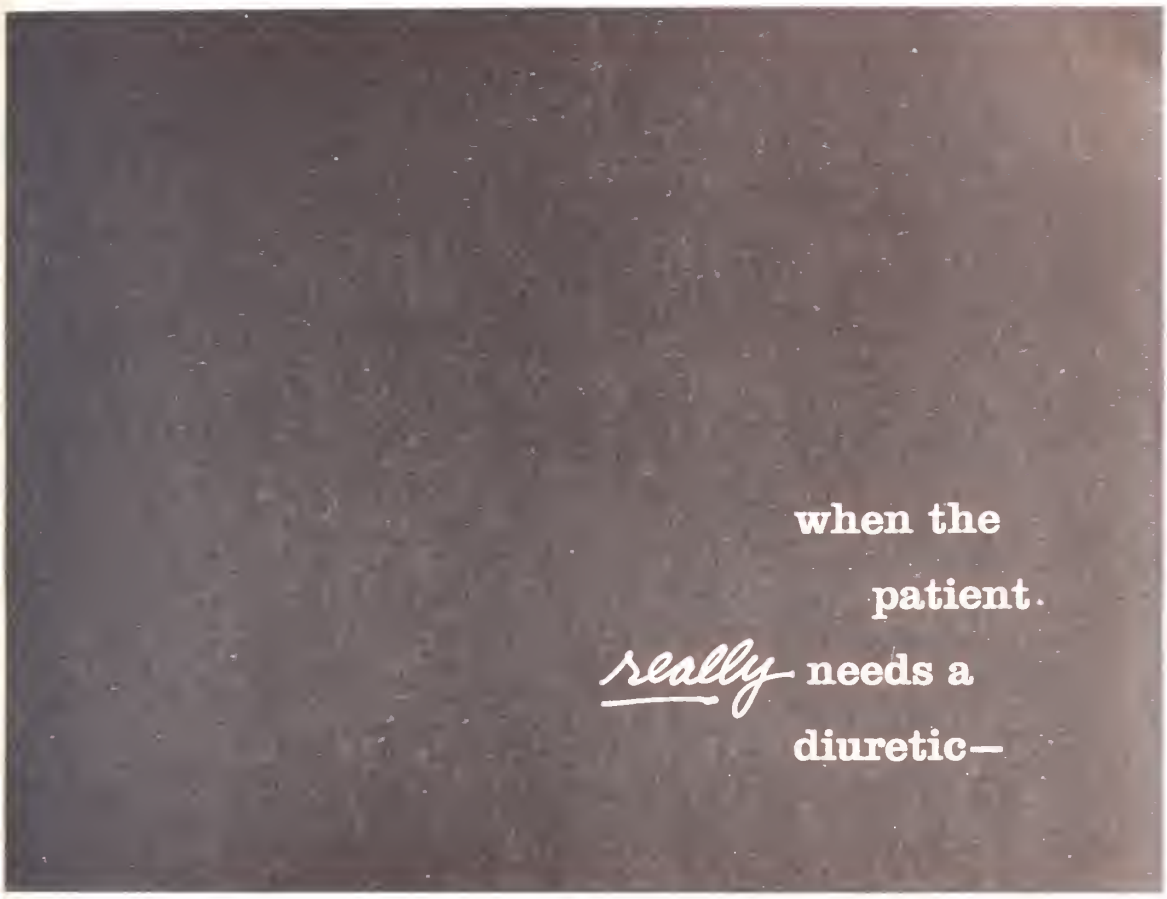
The VICEROY filter tip contains 20,000 tiny filters made exclusively from pure cellulose . . . soft, snow-white, natural. This is twice as many filters as the other two largest-selling filter brands.

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King-Size Filter Tip **VICEROY**



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But when cardiac decompensation—mild, moderate, or severe—is established, dependable and continuously effective diuresis—obtainable only with potent oral organomercurials—is a therapeutic necessity.

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Meat...

and the Value of Fat in Nutrition

Authorities in the field of nutrition no longer consider fat as an optional component of the diet. Evidence from the laboratory and bedside indicates that fat in small amounts may be looked upon as an obligatory constituent of a health-promoting diet.[1]

The far-reaching value of fat in nutrition has been amply demonstrated in laboratory animals in its pronounced effect on growth, on pregnancy and lactation, on nitrogen-sparing action, on work capacity, on time of sexual maturity, on the period of survival during fasting, and on ability to combat external stresses.[1]

Young animals fed a fat-free diet not only fail to grow normally, but develop hair and skin changes characteristic of "essential" fatty acid deficiency.[2] Fatty acids other than the "essential" fatty acids also appear to be necessary for optimal health. Animals fed "essential" fatty acids but no others do not grow optimally.

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1. Deuel, H. J., Jr.: Newer Concepts of the Role of Fats and of the Essential Fatty Acids in the Diet, Food Res. *20*:81 (Jan.-Feb.) 1955.

2. Meng, H. C.: Preparation, Utilization, and Importance of Neutral Fat Emulsion in Intravenous Alimentation, in Najjar, V. A.: Fat Metabolism, Baltimore, The Johns Hopkins Press, 1954, pp. 69-92.

The nutritional statements in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

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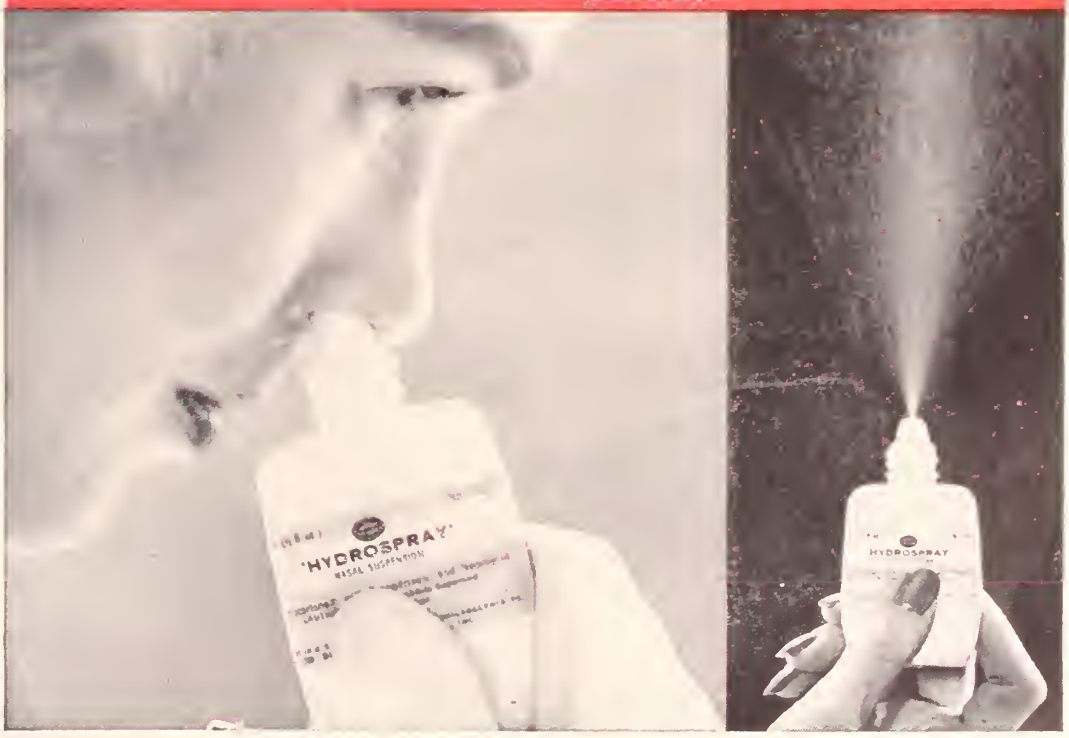
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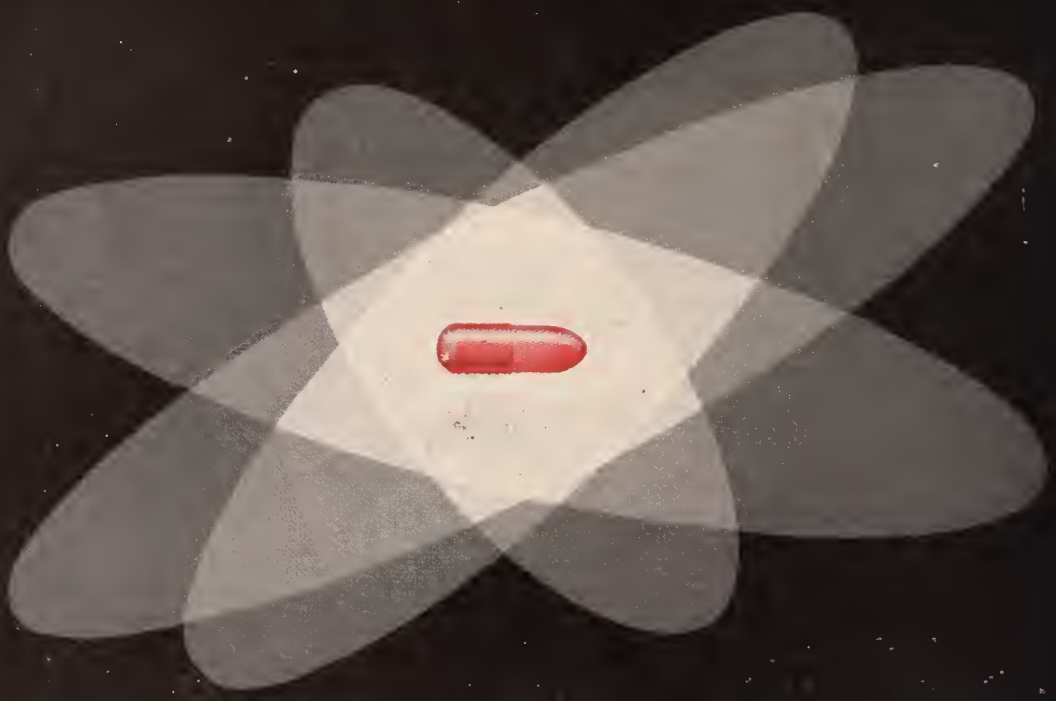
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Editorials • • •

For the Record

Doctors often pride themselves on being more concerned with care of the patient than with "paper work." And indeed, whenever the situation poses that dilemma, the physician obviously must elect to attend to the patient before he attends to papers. However, the dichotomy is seldom presented that dramatically. Usually, there is time to make an accurate and adequate note on the record—whether it be the office chart or the progress note sheet in the hospital record. Reasons for concern about good record keeping are both medical and legal. The professional reason is, or should be, obvious. Diagnosis is usually impossible without history. And those who see the patient later—(and that includes yourself) have to have a reliable record of earlier medical contacts to get a good history. The patient today who asks for some more of the green medicine that was so helpful back in 1941—what is he going to get now? What had you given him then? Do your records give the answer?

This is the era of chronic disease. With wonder drugs cutting down the morbidity and mortality of acute illnesses, today's practice is largely in the field of chronic diseases. But chronic diseases can be seen and identified in full perspective, only by a 3-D history of the illness. Can you diagnose multiple sclerosis on the basis of numbness and scotomata today? No, you can't. But if a well-recorded history showed that last year you, or some other doctor, had found a positive Babinski, nystagmus, and pallid retinae, then you have something you can count on. To put it crudely, medical practice clouded by sloppy records, is sloppy practice.

And there are compelling legal reasons. From the patient's viewpoint, the record you keep may make it possible for him to collect disability insurance or social security benefits; or your poor records may rob him of such benefits. Your records may establish a widow's entitlement to double indemnity, a veteran's entitlement to compensation. To keep careless

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records is sheer irresponsibility in this world of widespread health insurance.

Finally, there are legal reasons involving you, yourself. For one thing, a visit to the doctor is an event with a capital "E" to a patient though it may be a routine occurence to you. So, when the patient burns himself with the lamp or with the ointment, he says you told him to keep the lamp 5 feet away and keep it on for 15 minutes. And you say you told him to keep it on for 5 minutes 15 feet away. You said wipe off the ointment after 60 seconds but the patient insists that you told him to wipe it off only if it burned. So it's one man's word against the other's. If the doctor's record reflects his instructions, he is probably going to prevail. Otherwise, the jury will figure (a) it is a careless doctor who keeps bad records, and (b) the patient is more likely to remember than the doctor because the event is so dramatic for the patient.

In cases like this, and in certain income tax matters, a well kept record may save your pocketbook and even your reputation. If the sound professional reasons do not prevail, maybe these less noble but pragmatic ones will.

Physicians and Engineers

With the invasion of medicine by automation, the engineer has become a member of the medical team. The development of electroencephalography, audiometry, electrocardiography, and roentgenology (to name a few obvious fields) would be impossible without engineering talent. Dr. Kessler had to follow engineering principles when he developed the cineplastic arm, and indeed, much of the field of physical medicine and rehabilitation is as dependent on engineering skills as on medical ones. An "artificial kidney," a mechanical heart, an electronic brain are instances of the engineer's mimicry of nature. The respirator, the pulmotor, the iron lung, the automatic blood counter, Dengrove's electrical crib vibrator, the feed-back anesthesia depth control, the electronic stethoscope, and so on—and on—down a list of new medical instruments which represent the offspring of the union of the two professions. Ultrasonics, radio-isotopes, electronic microscopes, hearing aids, contact lenses, shock therapy machines, and mobile prosthetic joints are more examples.

Collaboration between the two professions is in the cards. Aeronautical medicine (maybe, soon, space medicine), weather-proofed clothing, atomic sickness controls, better limb prosthesis, speech and hearing corrective therapies, stress research, studies of electrical brain potentials, are in the van of the medical march, and all of these need engineering assistance.

Although a friendly and reciprocally stimulating cooperation is needed by both, few engineers have any direct contact with physicians, and fewer physicians have anything to do with engineers. There are historical as well as temperamental reasons for this lack of contact. An engineer cannot be a lone wolf. Engineering is, *par excellence*, a team-work practice. Doctors have, for centuries, prized the highly individualistic nature of the physician-patient contact. While medical groups are expanding, most medical practice is still pretty much of a solo operation—which, it seems, is the way most physicians want it. So, on this platform alone, the two professions are apart. Then too, medicine is an old profession and its ways have worn a groove in the community consciousness. It is stabilized, well-established, easily identified. Engineering is a relatively new profession, and the man on the street has little contact with—and less understanding of—engineers. The work of the M.D. can be simply explained: he helps you when you are sick. But the work of the engineer? This roams all over the world—sanitary engineering, mechanical engineering, military engineering, chemical engineering and so on through a dozen ramifications. No simple phrase (like "care for the sick") can delineate the scope of the engineer's mission.

Engineers are justly proud of their work.

They can say that of all the professions, they are the only one that consistently pays off on its promises. The poets dream of beauty, the philosophers plan an ideal world, the politicians promise one, the clergyman tries to uplift us, the doctors struggle to postpone death, the lawyers will give what advice they can—but all of them (really, all of *us*) have a high failure ratio. But when an engineer builds an airplane—it flies. When an engineer builds a bridge, it stays up. Engineering works. So engineers must view the rest of us as idle promisers, working with vagaries, while they work—with brilliant success—with concrete material—both literally and figuratively.

When engineers and doctors work together, they accomplish wonders. The Panama Canal could not have been built without the *joint* efforts of physicians, sanitary engineers and mechanical engineers. Without the *combined* efforts of the two disciplines, the x-ray would have remained a toy. And so with all these extraordinary tools which engineering has built to help us.

The first group to build a bridge between the two professions will make an enormous contribution to human progress. Why not joint meetings, joint seminars? Why not teach the engineers something more of the human body and human mind? Can we jam a little fundamental engineering into the over-crowded medical school curriculum? To be sure the body is *not* just a machine—or if it is, it is a machine operated by a curious ghost. But there is enough of the machine in the human body to need the help of the engineer. And we, in turn, can open to the new engineer, a vision of a challenging, stimulating—to use an old fashioned word—a "thrilling" career which can tax the best skills of both of us.

New York Society Reaches Sesquicentennial

The Medical Society of New Jersey, now entering its 191st year, takes this occasion to congratulate its junior big sister, the Medical Society of the County of New York which soon starts its 150th year.

New York County, the island of Manhattan, has the nation's largest county medical society. It carries on the traditions of medicine in the busiest and most critical spot in the nation in terms of medicine. We use the word "critical" without reference to the health of the citizens of New York. Their health is excellent and is the true measure of the job the physicians of our largest city are doing. But we use the word "critical" in connection with the newer problems of organized medicine — matters of medical economics, public relations, health information, medical care plans, public service projects—like 24-hour emergency call service and grievance committee, and the other facets of modern medical organization which affect the position of medicine in the public esteem.

What the Medical Society of the County of New York does in such matters reflects upon the nation's profession and is swiftly felt here across the Hudson. Its every act is taken in the bright searchlights of the nation's center of press, radio and television and great newspapers and magazines.

That the Medical Society of the County of New York achieves high status by this very difficult yardstick of public and press opinion, is a measure of its current leadership and its progressive and forward thinking. We, therefore, extend congratulations on this sesquicentennial celebration not only for its distinguished achievements of the last 150 years, but also for its current ability to prove, for all the nation to see, that medicine is a public service profession of honorable tradition.

So we, the next door neighbor, felicitate our younger sister across our border river. We have derived much from being so close to the New York County Society. They have been generous in placing facilities at our disposal.

Congratulations! The first 150 years are the hardest! Ask older brother. We know.

JACOB SCHMUKLER, M.D.
Newark

Amputations in Peripheral Vascular Disease*

A new specialty is now going through its accouchement. This is angiology: the care of peripheral vascular lesions. Here is a pioneer paper in angiology, a compact manual of amputation surgery for peripheral vascular disease.

UNTIL the cause of organic occlusive vascular diseases is definitely established, and prophylactic measures taken to prevent them; until lipid metabolism can be controlled to prevent atherosclerotic plaques from adhering to the intima of arteries; until thrombosis and embolism can be prevented and it will be routine to excise arterial segments and replace them with homografts or plastic tubular substitutes; until all this happens, peripheral vascular specialists will be continually confronted with the problem of rescuing "medical" therapeutic failures. These failures result in slow progressive ischemia and eventual death of tissues, with or without secondary infection intervening. Instances of sudden onset of gangrene of an extremity result from an acute occlusion, either thrombotic or embolic, in which embolectomy may sometimes, but not always, prevent mortification of the tissues.[1]

Whatever the cause, the development of gangrene in an extremity necessitates its removal, early or late, in part or in whole. Proper procedure in amputation surgery will spell the difference between success or failure in the treatment of these medical therapeutic inefficacies, and is the subject of this paper.

DIAGNOSIS

THE various occlusive diseases associated with the occurrence of gangrene are:

1. Arteriosclerosis and atherosclerosis, with or without diabetes
2. Thrombo-angiitis obliterans
3. Embolism or thrombosis
4. Polycythemia vera

The gangrene which results from any of these causes may be slow or rapid, localized or extensive, with or without infection. The extent of gangrene encountered will influence the type of operative procedure.

Gangrene is most frequently associated with the metabolic diseases of arterio and atherosclerosis.[2] Both diabetics and non-diabetics survive to an age when they may develop occlusive vascular disease in which gangrene can occur, necessitating surgical intervention. Ischemia is the common denominator for all of these conditions. No single method of effective treatment for the occlusive vascular diseases has, as yet, been discovered and spontaneous complications are not controllable.[3] Two-thirds of all amputations are due to the progress of the disease itself. The other one-third can be ascribed to the neglect of the patient and the treating physician in equal measure.

The patient is culpable when he disregards the importance of diabetic control, neglects the care of his feet, uses local escharotics, fails to wear properly fitted shoes, is derelict in the treatment of burns or minor accidents and ig-

*Read by invitation before the N. J. Chapter, American College of Surgeons, January 26, 1955 at Paterson, N. J.

nores the warning symptoms of impending gangrene.[4] The physician errs when he fails to establish a diagnosis, tenders improper treatment and employs poor technic in doing minor amputations.

Arteriosclerosis is predominantly a disease of males. When, however, diabetes is associated with the arteriosclerosis, a higher proportion of patients will be found among females.

PATIENTS who rarely develop gangrene will complain of symptoms for a longer period than those who are destined to develop gangrene with subsequent amputation. In these prospective amputees, gangrene occurs shortly after the onset of disease. This may be due to the fact that they suffer a more progressive form of the disease with a hastening and telescoping of the symptoms.[5]

Calcification of arteries does not necessarily bear any relation to the presence or location of an arterial occlusion. Seventy-five to ninety per cent of the blood supply to an extremity may be lost without impairment to normal activity because of the presence of adequate collateral circulation. It is only when there is greater need for an increased amount of blood that the diseased state of the extremity becomes evident.

Buerger's Disease is now more frequently found, both in males and females, due to the increased use of tobacco.[6] The gangrene of Buerger's Disease may involve the upper as well as the lower extremities. Major amputations of the upper extremities are rarely found necessary, though individual finger amputations frequently are. Because Buerger's Disease is essentially a disease of the comparatively young, conservative therapy is advisable, unless the physician encounters a fulminating gangrene with extremely severe pain.

Spontaneous acute thrombosis of a major artery is most commonly found as a complication of arteriosclerosis obliterans. This complication may be due to the rupture of an atheromatous abscess or a spontaneous subintimal hemorrhage. Onset is acute and may produce complete obstruction of a major arterial pathway. The extent of the resultant gangrene will depend on the presence of collateral circulation. Acute thrombosis of an artery may also be encountered in polycythemia vera due to the alteration in viscosity of the blood with increase of the cellular elements.

An acute arterial embolus produces the same clinical result, that is, gangrene. The source of the embolus is centrally located as in arteriosclerotic heart disease or mitral stenosis associated with auricular fibrillation. Emboli are always lodged at an arterial bifurcation, whereas thrombosis may occur in any portion of an artery. Correct diagnosis here is of primary importance because embolectomy is a surgical emergency in this type of occlusion.

PRE-OPERATIVE CARE

THE greatest progress in the management of peripheral vascular problems can best be achieved by a group of physicians and surgeons who are essentially interested in this specialty.[7] They should work as a team and be willing to devote the required time and care to the treatment of their patient. Standardization of therapy would be advantageous both to the physician and to the patient. Though painstaking, without glamor and often frustrating, these problems must be an essential consideration of the medical profession because of the ever greater needs of an ageing population.

The prognosis of a patient suffering from gangrene associated with other debilitating diseases is, as a rule, not good. Associated diseases encountered in these patients of middle or old age are diabetes, heart disease, hypertension, cerebrovascular disease, cancer, polycythemia, malnutrition and anemia.

An attempt should be made by the internist of the team to correct, if possible, some of the associated maladies pre-operatively. With the use of antibiotics and anticoagulants, one can be more courageous in the surgical handling of these cases with a substantial reduction in the incidence of major amputations. Delay is possible and conservatism is indicated while

the patient is being rehabilitated by transfusion and other necessary medications. Such a conservative course of action could not be advocated before the advent of antibiotics. Since these drugs have become available, the site of amputation and the mortality rate have both been lowered.

OPTIMUM TIME FOR OPERATION

THE optimal amputation time varies in each individual and no hard and fast rules can be laid down. Factors, such as infection, vascular supply, age of the patient and his response to therapy, are involved. The mortality rate is often lowered by a wise decision. Where infection is minimal and controllable, in Buerger's Disease, arteriosclerosis and in diabetes, ultra-conservatism is advocated. A necrotic toe should be permitted to demarcate. If infection spreads, then immediate amputation of an extremity may be a life-saving measure. In the embolic and thrombotic types of gangrene, amputation should be delayed from one to three weeks to allow time for demarcation and development of collateral circulation. Such a course of procedure is more feasible in cases of 'dry gangrene'. Amputation for pain can be performed at a time suitable to all concerned. Certainly no amputation should be performed due to the surgeon's impatience or the shortage of hospital beds. A patient's leg, on the scale of human values, will far outweigh a few extra days, weeks, or even months of conservative therapy.

Sympathectomy cannot affect the pathologic changes in the blood vessels nor the course of the underlying disease.[8] The increased blood flow in an extremity following the extirpation of the sympathetics is in the skin alone, and not in the muscles.[9] Sympathectomy is frequently done in the hope that the results will have warranted the operation. I do not believe that sympathectomy, whether chemical or surgical, will ever hold an important place in the treatment of these conditions in view of the type of pathology present. However, if time should prove this operation effective, then it should be universally adopted. Its validity has not as yet been established.

AMPUTATION SITE

WITH antibiotics and with experience in treating peripheral vascular diseases, greater conservatism is exercised in choosing the site for amputation. In the lower extremity, the five suitable levels for amputation are: the individual toes, transmetatarsal area, supramalleolar area, below the knee and mid-thigh. The criteria for the choice will be the extent of gangrene or ulceration, the degree of infection, the condition of the adjacent areas, the measure of arterial impairment, the severity of the pain, and the general condition of the patient.[10]

1. *Single toe amputation* may be done for dry gangrene or an ulcer of the distal end with good demarcation. This is most suitable for 2nd, 3rd and 4th toes.

2. *Transmetatarsal amputation* with primary closure is indicated in gangrene limited to the toes. When infection is present, an open guillotine amputation at this level, may be attempted. If the gangrene spreads to the foot, a transmetatarsal operation is no longer feasible. This type of surgery should be performed whenever possible. The benefit to the patient, which should take precedence over all others is that the transmetatarsal amputee can walk comfortably without a prosthesis. This procedure is especially valuable in pathology affecting *both* lower extremities. It is the surgeon's responsibility to inform the patient before surgery that, should this operation fail because of insufficient blood supply, a below the knee amputation will be necessary.

3. *Supra-malleolar amputation* is done only as a life-saving measure in the presence of fulminating infection or severe associated diseases such as carcinoma. There is no shock. The operation time is short. A more definitive type of amputation can be performed later.

4. *Mid-leg amputation* shou'd be done whenever possible if there seems a reasonable chance for healing. Age is no contra-indication. Mortality is considerably less than in mid-thigh amputation. A knee joint is a valuable possession. This operation should be attempted even with an absent popliteal pu'se if there is good collateral circulation. Among older patients, many more can, and do, wear a "below-the-knee" prosthesis rather than an "above-the-knee" false leg. Mastery of such a prosthesis is easier and it weighs less. This is an important consideration with cardiac and hypertensive patients and in those with bilateral amputations, because it avoids total invalidism.

5. The three major indications for *thigh amputation* are (1) extensive gangrene plus infection of the leg with absent femoral pulse; (2) gangrene of the foot associated with the flexion contracture of the knee joint; and (3) recent thrombosis or embolism of the femoral or iliac artery with a high level of gangrene. Although primary closure with healing is better at this site, it carries a high mortality rate and should be avoided whenever possible.

PSYCHOLOGIC PRE-CONDITIONING

THE average patient is apprehensive about surgical procedures in general. He faces the loss of limb with considerably more fear, grief, and anxiety. A common reaction is: "I would rather die than lose a leg." A patient chronically ill with this disease has already spent years trying to save his leg. By the time such surgery becomes necessary, his morale has tailspinned, his physical stamina is low, and his financial means and feeling of security have been considerably diminished. Such a patient fears to face the future socially and economically. He is in dread of becoming a burden to himself and his family. Reassurance is not enough. The patient must be given a clear picture of his disability and future adjustment. If presented properly, and if the occasion is provided to meet amputees who are not only ambulatory but useful, the surgeon is able to convince the patient and gain his cooperation. This is an unglamorous task, but it is a necessary one. Amputation should never be performed without the patient's knowledge, unless as an emergency life-saving measure. The emotional shock is of lesser magnitude when the patient has been properly prepared before, rather than after an amputation.

ANESTHESIA

ANESTHESIA plays a great role in the care of the emotionally shocked and physically degenerated patient with occlusive vascular disease. General anesthesia is not recommended in these patients because of its pulmonary and embolic complications. Local anesthesia constricts the small vessels when the tissues are infiltrated by the injection material. Refrigeration anesthesia is now used only in debilitated patients with severe sepsis, disorientation and lack of diabetic control, as an emergency measure. The perfected, one-leg, low spinal anesthesia is best for amputation.

TECHNIC

THE classical amputations are not done in peripheral vascular disease because of the patient's age and physical condition and because of the underlying vascular deficiency of the extremities.

Healing depends on adequate circulation, so that whatever pre-operative diagnostic technics have been used to determine the adequacy of the circulation, the ultimate decision as to the site of operation, will be the presence of bleeding at the point of incision.[11] Bleeding is the best direct measure of collateral circulation. The normal pink appearance of the muscle is another indication of tissue viability. A greyish 'cooked' appearance alerts the surgeon to the realization that there will be further spread of gangrene. Therefore, if a "below-the-knee" incision is made and there is insufficient evidence of bleeding, the surgeon must then go to a higher level below the knee or to the middle or upper third of the thigh. *Flaps should never be made.* The skin must not be separated from the underlying fascia. A circular guillotine incision has proved to be the best. Even 'dog ears' should not be excised, for gangrene of the skin may result at these points. The femur, tibia and fibula should be cut short enough to allow for subsequent soft tissue retraction. The sharp anterior surface of the tibia at its lower edge, being subcutaneous, must be roundly bevelled to avoid subsequent prosthesis pressure.[12] Large nerves, like the sciatic should be injected with 1 per cent procaine before high sharp sectioning to avoid shock to the patient. The retraction of the nerve end above the wound will help to prevent neuroma and phantom pain. This serious postoperative complication occurs more frequently in "above-the-knee" than in "below-the-knee" amputations. To close the wound edges, sew only the skin and fascia with thin black silk or stainless steel wire, gently approximating the edges without instruments and without tension. If in doubt as to healing by primary closure, the wound is best left open to heal by secondary granulation. A posterior splint is always necessary in "below-the-knee" amputations to prevent flexion contractures of the knee joint. For "below-the-knee" amputations, the best operation position is with the patient on his abdomen. Always expose and examine both legs before beginning the operation, to avoid any tragic consequences.

"POSTOPERATIVE CARE"

THE same teamwork which characterized the pre-operative care on the part of the internist and the surgeon, is necessary for the successful postoperative care of the patient. Immediate medical attention is necessary to avoid complications which may ensue as a result of the associated pathologic findings. Supportive therapy is essential for proper postoperative treatment.

Surgically, the wound is not disturbed for 7 to 10 days unless there is a systemic reaction. If Parresine® mesh is used directly on the wound, there will be no adherence of the dressing to the skin or the exposed muscles in an open guillotine operation. Sutures are removed a few at a time, and if no wound tension is present, may be permitted to stay in longer. The patient should be put in a wheel chair one day after the operation, and if there are no contra-indications, he should be exercised in a walker shortly afterwards. It is not wise to hasten stump revision in the presence of skin necrosis along the suture line. Given time it will heal.

Instructions should be given to the patient for active contraction of the quadriceps muscle in a "below-the-knee" amputation, and the side to side movement of an "above-the-knee" stump. The posterior splint in a "below-the-knee" amputation should be removed only when there is no longer any tendency for flexion contracture of the knee. When the stump is healed, shrinking and conditioning for fitting a prosthesis is to be begun by the proper use of ace bandages.

In the meticulous attention paid to the operation site, the other leg is frequently forgotten. The increased pressure exerted on the bed by the heel of the remaining foot can cause pressure necrosis which can spread rapidly, necessitating a second amputation. A foam rubber sheet placed under that heel will prevent such pressure necrosis. *A cut down on the remaining foot for transfusion or intravenous therapy should not be permitted.* Such procedures have often caused spreading gangrene at the site of the cut down incision, with dire consequences.

REHABILITATION

THE surgeon's task is not completed with the healing of the stump. Rehabilitation is important and should not be overlooked.[13] The aid of the family and all persons who come in close contact with the patient should be enlisted. Rehabilitation will lighten the postoperative care of the amputee. The patient should be assured that he is not going to be helpless. He should be encouraged to use crutches and make his own toilet. The younger patient should be urged to return to his job, and hobbies offered to the man or woman who is too old to work. This will help neutralize the shame and depression which these patients feel because of their helplessness.

If family circumstances do not permit this type of rehabilitation at home, the amputee should then be sent to a rehabilitation center, where he will be cared for by professional personnel and will have the opportunity for group training.

PROSTHESIS

IT BEHOOVES the surgeon to familiarize himself with the problems of prosthesis. The best way is to visit a limb manufacturing establishment and observe how the limbs are made and fitted. Limb makers should be cautioned about undue pressure during stump conditioning and subsequent weight bearing. Limbs are made of willow wood or light metal. In peripheral vascular disease, fit and the avoidance of pressure are the important things. In a "below-the-knee" prosthesis, fifty per cent of the weight is borne by the thigh lacer or corset. The other fifty per cent of the weight bearing is on the internal condyle of the tibia, the tibial tubercle and the head of the fibula. The skin over these bony prominences is not biologically fit for weight bearing and may break down. In all "above-the-knee" prosthesis, 75 per cent of the weight is borne by the ischium and 25 per cent on the circumferential skin and soft parts of the stump. Stump socks cushion the pressure also, as well as the shock of walking. In spite of these precautions, increased pressure and impaired circulation of the stump in these

cases cause a breaking down of the tissues with a spread of gangrene, sometimes necessitating stump revisions.

PREVENTING AMPUTATION

THE specialty is no longer limited to amputation but includes the following procedures:

1. Aortography and arteriography for diagnosis
2. Embolectomy in acute occlusions
3. Arteriectomy and thrombo-endarterectomy
4. Substitution surgery with homografts, veins and tubes made of plastic materials.

It may be within the realm of possibility substantially to reduce the number of major amputations because of the progress of both research and surgery in the peripheral vascular field.

100 AMPUTATIONS

PERSONAL experience with one hundred amputations reveals the following statistics, which follow the pattern of those reported in the current literature. The age range was 36 to 84. Average age was 66. Of the 100 patients, 41 were female.

CAUSES

48	Arteriosclerosis
33	Arteriosclerosis with diabetes
3	Buerger's disease
8	Embolus
7	Thrombosis
1	Polycythemia

SURGERY

21	Mid-thigh
54	Mid-leg
11	Transmetatarsal
14.	Individual toes
28	Open
72	Closed
10	Bilateral
6	Revisions

CONCLUSION

AMPUTATION surgery in peripheral vascular disease is on the increase because the metabolic diseases have become more prevalent in an ageing population.[14] The very presence of gangrene and the necessity for amputation is an admission of defeat by the angiologist. Advances in vascular surgery, the use of antibiotics and anticoagulants have decreased the mortality and morbidity and have enabled the surgeon to be more conservative in his choice of incision site and the optimal time for operation.

Sympathectomy is not now the answer to the problem. Of much greater import is correct early diagnosis, proper pre- and postoperative care, psychologic preparation of the patient before operation as well as postoperative rehabilitation. Conservatism in treatment, and type of amputation depending on the condition of the patient, the extent of infection, and the reserve vascular supply, are the paramount considerations.

Vascular surgeons have the responsibility of showing their ageing amputees the way to be useful members of society. They need not exist as helpless maladjusted human beings. It is the hope of all vascular specialists that the progress in surgery and research in the field of peripheral vascular disease will lead to a reduction in the number of major amputations which are now memorials to "medical" therapeutic failures. It is also our hope that more physicians will devote themselves to the treatment of these diseases because, only if the number of specialists is augmented, can the increased number of patients involved, expect and receive, adequate medical and surgical help.

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Bibliography will appear in author's reprints.

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Brain Tumor Complicating Pregnancy

Vomiting in pregnancy is common enough and seldom indicates a brain lesion. But sometimes a pregnant woman does have a brain tumor, and then the tragedy is made doubly poignant by misdiagnosis. This case reminds us of the wisdom of getting a neurologic examination, electro-encephalogram, skull x-ray and retinoscopy whenever vomiting is accompanied by visual disturbances in a pregnant patient.

It is not uncommon for cerebral complications (cerebral hemorrhages or brain tumor) to occur during pregnancy. But it seems an oversight, according to Rand and Andler[1] that in standard works on obstetrics and neurosurgery, so little attention is paid to brain tumors in pregnancy. Severe headaches with dizziness and visual disturbances and attacks of stomach distress with vomiting, convulsions, hemiplegia and attacks of syncope during pregnancy have been generally regarded as related to toxemia. But this is not always the case. Some come from conditions latent and present long before the pregnancy, and are not part of childbearing.

During gestation the patient may complain of the above listed symptoms which increase in severity and frequency during the middle and latter months. While these conditions may be regarded as pernicious vomiting and toxemia of pregnancy or threatened eclampsia, they may also be symptoms of brain tumor, especially if the patient has had these intermittent headaches previous to pregnancy. A slowly growing neoplasm may gradually compress the surrounding brain substance for years before definitive symptoms develop and (by encroachment on certain brain centers) give rise to these disturbances. Here is a case in point.

This patient was 26 years old and in her third pregnancy. She had previously been in excellent general health. First pregnancy was at the age of 17 and ran a normal course with no adverse symptoms, but the labor at term was rather protracted. She had twins, each being of large size. The girl baby weighed ten pounds. The other was an eight and three-quarter pound boy, born 24 hours later. Each was delivered spontaneously with vertex presentation and both living. The mother had a normal puerperium and afterwards kept in good general health.

Her second pregnancy was six years later and ran a fairly normal course with spontaneous delivery at term of a living eight and three quarter pound boy. During this pregnancy, however, the patient had headaches, with occasional dizziness, blurring and haziness of vision, and temporary numbness of hands, but with suitable medication these symptoms apparently cleared up. There was no reason to think that these symptoms might be due to a focal brain lesion. During the third pregnancy the patient complained more frequently of headaches and vomiting. She was given alkaline antacid tablets, belladonna, magnesium trisilicate, and charcoal tablets. This relieved the gastrointestinal symptoms, but her headaches persisted. Then the vomiting returned and became so severe that she could not keep anything on her stomach in spite of medication. She was sent to the Burlington County Hospital with a diagnosis of per-

1. Rand, C. W. and Andler, M.: Archives of Neurology and Psychiatry 63:27 (Jan. 1950)

nicious vomiting of pregnancy, possible toxemia and threatened eclampsia.

At the hospital, skull x-ray showed no abnormality of the calvaria. The sella turcica appeared normal in size with normal anterior clinoid processes and no undue thinning of the dorsum sellae. The pineal body was not calcified. But with increase in headache and spells of dizziness, visual disturbances and temporary numbness of hands especially the left, the condition was suggestive of brain tumor.

Three days later she returned home. Her headaches were less frequent and intense, and her digestive symptoms improved for a time. Soon these symptoms and seizures recurred with more intensity and with photophobia, and she was sent to the Jefferson Hospital in Philadelphia with a diagnosis of a brain tumor. She was comatose on admission.

Neurologic examination was negative except for severe papilledema and suggestive weakness on the side. Right carotid arteriography revealed a large parietal lobe lesion. At craniotomy, a highly vascularized glioma was found. Half of it was removed. A Cesarean section was done under local anesthesia. A live female infant weighing 4 pounds, 13 ounces was delivered and put in the incubator. The mother lived for 4 months after partial loss of vision with macular degeneration, having no light perception. The patient had never told about previous focal seizures until after she came to Jefferson Hospital. It was the opinion of Dr. Rudolph Jaeger, the neuro-surgeon, that, although the microscopic report was oligodendroglioma further surgery would be fatal.

A month later she had a sudden spell of unconsciousness with twitching of leg and face followed by flaccidity. Consciousness gradually returned and the patient would answer when spoken to and was able to move her limbs and turn on her side. This spell was evidently a focal epileptiform type due to cerebral vascular disturbances. For two weeks she seemed better and free from convulsions, but then she had five successive epileptiform convulsions. She was given inhalations of amyl nitrite, and diphenyl hydantoin by mouth, as well as capsules of pentobarbital.

Her condition gradually grew worse with intense pains in the neck muscles and in limbs. Deafness set in and vision gradually failed completely. She became more comatose, with difficulty in making her wants known and lost control of bladder and bowels. The brain tumor increased in size and protruded from the skull opening. She died after lying for six days in a comatose state.

This highlights the importance of looking for brain tumors in pregnancy if the patient has persistent headaches with visual disturbances and vomiting attacks. This, at first, suggests toxemia of pregnancy, but in this case was really due to a slowly growing neoplasm developing insidiously for two years previous to the third pregnancy. If a pregnant woman is suspected of having a glioma, prompt operative intervention is indicated because there is a greater edema of brain tissue surrounding a glioma than adjacent to a benign tumor. Patients with the latter may wait more safely for operative treatment if the symptoms are not alarming, but all such patients should be watched with the utmost care so that surgical measures may be resorted to on short notice, if indicated.

Rand and Andler[1] have reviewed special problems associated with neoplasms of the brain in pregnancy. Though a meningioma is benign and of slow growth, it may be so located as to cause fulminating symptoms. With gliomas, the course is unpredictable. They vary in rapidity of growth and may occur in any part of the brain. An astroglioma or an astrocytoma should be attacked as soon as a diagnosis is made.

Cushing[2] cited a case where symptoms of intracranial pressure during pregnancy obscured the diagnosis. Increasingly severe occipital headaches and vomiting (at the time ascribed to toxemia) resulted in the pregnancy being interrupted at the eighth month, a healthy child surviving. Her headaches and vomiting continued after delivery, accompanied by rapidly failing vision. Three months later a brain tumor was suspected and a midline angioma was surgically treated at four sittings, the patient dying of pneumonia after the fourth treatment. In this case the pregnancy so obscured the early diagnosis that she was nearly blind before the tumor was observed. Pregnancy appears to be a not uncommon provocative agent in bringing tumors to light—especially angiomatous ones.

Breitenbach[3] stated that the clinical picture of brain tumors in pregnancy is not especially different from that in non-pregnant women, but that the appearance of convulsions towards the end of pregnancy and during delivery presents a difficult obstetrical problem. Here the physician is responsible for the life of both mother and unborn child.

2. Cushing, H. and Bailey, P.: Tumors Arising from the Blood Vessels of the Brain. Springfield, Ill. 1922. Charles C. Thomas, 167-178.

3. Breitenbach, W., Hirntumor and Schwangerschaft: Zentralblatt für Gynäk. 53:422 (Feb. 10, 1929)

In several reported cases of brain tumor in pregnancy prompt post-mortem Cesarean section has resulted in saving the baby. Meade [4] cited the case of a 24-year old woman who died in the seventh month of her pregnancy, who had had headaches, nausea, vomiting, and papilledema, which had first been considered "toxic." A living infant was delivered by immediate Cesarean section.

Duperrat [5] warns against always attributing convulsions during pregnancy to eclampsia, for tumors of the brain may, and often do, cause convulsions. And as Alpers and Palmer [6] point out, a toxemia may be associated with changes in the discs.

According to King [7] gliomas of the brain may seem to grow with rapidity, but their behavior is very variable. The effect of pregnancy on angiomas and on neuromas is sometimes very evident.

SUMMARY

HEADACHE with visual disturbances and vomiting attacks during pregnancy (especially during the middle and latter months) are usually ascribed to autotoxemia and suggestive of threatened eclampsia. But they may be symptoms of brain tumor, sometimes developing long before the gestation period and due to the growth of the neoplasm and its pressure on the adjacent brain centers. A case is presented of a 26-year old woman in her third pregnancy who had severe headaches, vomiting and visual disturbance, which proved to be "focal epilepsy." These grew more severe as gestation progressed. At 8½ months she was sent to Jefferson Hospital in a comatose condition. She was operated on for a parietal lobe oligodendroglioma, of which only half was removed as it was felt that further brain surgery would be fatal. At Cesarean section, she was delivered of a living infant. The patient developed epileptiform convulsions and eventually lapsed into a comatose state and died.

The writer gratefully acknowledges his indebtedness to Dr. Rudolph Jaeger for the report of the hospitalization and surgical treatment of the patient.

4. Meade, W. H.: Journal Michigan Medical Society 34:243 (May 1935)

5. Duperrat, B.: Tumeur Cerebrale et. Grossesse. *Presse Medicale* 53:118 (March 10, 1945)

6. Alpers, B. J. and Palmer, H. D.: Journal of Nervous and Mental Diseases. 70:463 (Nov.) and 606 (Dec.) 1929.

7. King, A. B.: Archives of Neurology and Psychiatry 63:491 (March) 611 (April) 1950.

44 Broad Street

Neuroanatomy Course

A course in neuroanatomy is available without charge to physicians of this state. Given by Dr. David J. Flicker, the course is held at and under the auspices of the Veterans Administration Hospital in East Orange.

The class meets every Friday morning at 8:00 a.m. and concludes at 9:00 a.m. No registration is required. The class meets on the fourth floor of the hospital. The course began on February 24, but each lecture covers a separate part of the neuraxis and attendance at previous sessions is not necessary.

Irving Maisel, M.D.

Newark

Studies on Male Infertility*

In 133 cases of oligospermia, 12 pregnancies were developed as a result of the treatment here outlined. A batting average of less than 10 per cent is, perhaps, not spectacular; but it is infinitely better than zero.

This is a review of the management of male infertility based on 216 cases studied in a four-year period ending December 31, 1954. There was close cooperation between the urologist and the gynecologist in that the women were treated for any condition that might have been a factor in the cause of sterility. The male patient was referred in the early part of the sterility workup and a routine history, physical examination and seminal fluid study was made.

SEMEN EXAMINATION

The method of semen examination as recommended by Farris[1] was followed rather closely. The count was done with a white blood pipette, diluting the fluid 1 to 20 with Ringer's solution. A Neubauer hemocytometer was used counting 5 groups of 16 small squares as in doing a red count and then adding 6 zeros to the total figure. The viscosity and turbidity was noted while drawing up the fluid. The volume was carefully measured. The motility was noted by studying a slide under high power with the percentage estimated by counting the living and dead sperm in one quarter of the field. The motility was followed for a period of 24 hours. The morphology was reported by counting 100 cells. Oval heads were considered normal, and pin-heads, giant, duplication or amorphous cells were considered abnormal.

There were 216 patients studied in this series with 12 reported as having normal sperm counts (Table 1). The normal figure accepted for our study was 50 million per cc. In overall management, most patients were given therapeutic vitamins, one daily, plus one grain thyroid extract three times a day, and a high protein diet. The actual amount of protein in the diet was left to the patient's discretion. He was told to eat more meat, drink more milk and eat more green vegetables. The patient was instructed in the value of abstaining before the ovulation time so that the maximum count might be available at the proper time.

TABLE 1.

Total number of cases	216
Normal	12
Azospermia	30
Oligospermia	107
Prostatitis	27
Refused Treatment	40

*Read before the Section on Urology, 189th Annual Meeting of The Medical Society of New Jersey, April 20, 1955.

1. Farris, E. J.: An Improved Method for Semen Analysis. Journal of Urology, 58:85 (1947)

TESTOSTERONE TREATMENT

TWELVE patients were treated with small doses of Testosterone®; that is, 10 milligrams once a week for 4 to 6 weeks. No increase in the sperm count was noted and this method was dropped (Table 2).

TABLE 2.

	Cases	Increase in Sperm Count	Pregnancies
Gonadotrophins	61	28	4
Thyroid	27	3	1
Small doses of Testosterone	12	0	0
Large doses of Testosterone	10	3	0
Prostatitis treated	27	0	4
Pituitary x-ray	22	5	3

Ten patients were given large doses of Testosterone® to try the "rebound phenomenon" reported by Heckel.[2] In his first paper he treated 5 patients and got a "rebound" far above the pretreatment levels. The patients in this series were given 50 milligrams twice a week for four weeks. In Heckel's work [2] the patients were given 400 milligrams. This was enough to result in an azospermia which is the criterion for the amount of Testosterone® necessary. These patients were followed for about one year after the azospermia was brought about. The expected "rebound" was obtained in three patients with the average count being doubled. In six there was a return to the pretreatment count in a three month period. The last patient of this group began with a 20 million count and ended with a 10 million count which has now been followed for 18 months. With this one bad result this method of treatment was dropped.

TESTICULAR BIOPSY

THERE were 30 patients who had an azospermia at the original examination. These were restudied after five days and the same condition noted. Of this group 8 had testicular biopsies done as inpatients at the hospital. The study was done mainly for its prognostic value. The cases all showed complete atrophy with no evidence of spermatogenesis. Nelson [3] feels the value of testicular biopsies is the screening out of patients in whom no response can be expected to any available therapeutic procedures.

Thirty patients accepted the diagnosis of oligospermia and refused any therapy.

GONADOTROPHIN TREATMENT

FORTY-ONE patients received gonadotrophins* with a dose of 1,000 units twice a week. Tyler [4] reported 9.5 per cent improvement in the sperm count on such a regimen. His patients were treated for 8 weeks. Those in this series were treated for 5 weeks. Sperm counts were checked after three weeks and at the end of 5 weeks. Twenty patients showed an increase of 20 per cent or more. No pregnancies, however, were reported in this group.

Twenty patients received large doses of gonadotrophins.* That is about 4 times the usual amount. A course of A. P. L.® followed by Equinex® (pregnant mare's serum) was given. The dosage was 4,000 units A.P.L.® twice a week for 5 injections followed by 1,000 units of the pregnant mare's serum twice a week for 5 injections. There were four pregnancies in this group along with sperm increases noted in ten other patients. In six cases there was no increase in total count.

TREATMENT OF PROSTATITIS

IN 27 patients, a definite prostatitis was associated with an oligospermia. In this group there were numerous pus cells in the seminal fluid. The prostatitis was treated with prostatic massage, hot sitz baths and penicillin

*Dr. J. Jewell, Medical Director of Ayerst, McKenna and Harrison, generously supplied the drugs

2. Heckel, N. J., Rosso, W. A. and Kestel, L.: Spermatogenic Rebound Phenomenon. J. of Clin. Endocrinology, 9:235 (1951)

3. Nelson, W. O.: Interpretation of Testicular Biopsy, Journal of the A.M.A. 151:449 (1953)

4. Tyler, E. T.: Semen Studies and Fertility, Journal of the A.M.A. 146:307 (1951)

for an average time of two visits per week for 3 weeks. The oligospermia remained unchanged but with the therapy directed at the prostate gland the pus cells disappeared. There were 4 pregnancies in this group within two months after treatment was stopped.

X-RAY THERAPY

TWENTY-TWO patients were treated with x-ray stimulation to the pituitary as suggested by Farris.[5] Farris treated two groups with x-ray stimulation. The first group exhibited 50 million or more moving cells. Eighty per cent of these responded to the treatment. This response was only temporary. Patients in the second group had less than 50 million moving cells. Here there was a response but to a lesser degree. In our series there were two pregnancies with the first two patients treated, the first in the first month and the second in the second month. Both patients had been treated by other methods for at least two years. Both patients had an oligospermia of 20 million with poor motility. There was a definite change in the motility but no change in the total count. The third pregnancy occurred during the month in which the treatment was started. No follow-up studies were made after the pregnancy. The therapy consisted of 100 roentgen units. One treatment was given 8 days before ovulation. The second treatment was given one day before ovulation.

There was one remarkable improvement in that the count rose from 20 million per cubic centimeter to 80 million with increased motility; but no pregnancy followed. No dangers are associated with this type of therapy.

In general, the patients were rather uncooperative in the sperm studies. As far as each patient was concerned, the only important result was a pregnancy. Farris[5] feels that one most important factor is to abstain from intercourse for the five days prior to the day of ovulation. This brings the active sperm count to its highest level.

SUMMARY

1. Two hundred and sixteen patients were examined. Twelve had normal sperm counts and were not treated. Thirty patients had a definite oligospermia and refused treatment.

2. Thirty patients had azospermia. In 8 cases testicular biopsies were done. In 41 cases with oligospermia, standard doses of gonadotrophins were given with almost 50 per cent improvement but with no pregnancy. Within this group there were 3 hypothyroids treated. One pregnancy followed.

3. Twenty patients were given larger doses of gonadotrophins (4 times the amount). There were 4 pregnancies in this group and 10 others with 50 per cent improvement.

4. In 27 cases of oligospermia, the prostatitis was treated. There were 4 pregnancies.

5. Twenty-two men were treated with x-ray to the pituitary. There were 3 pregnancies in this group.

6. Twelve men were treated with small doses of Testosterone® with no improvement. Ten were treated with large doses of Testosterone® with 3 men showing the "rebound" but no pregnancies.

7. In the overall results of cases treated with oligospermia, there were 12 pregnancies in 133 cases.

8. The best results were obtained with large doses of gonadotrophins.

5. Farris, E. J.: Evaluation of Sterility Problems of the Male. Journal of Urology, 63:748 (1950)

31 Lincoln Park

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Daniel Melvin, M.D.
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Syphilis Is Still Here*

Wonder drugs have not abolished syphilis, but they have made us forget to think about the disease. As reflected in this brief report, syphilis is still here.

Syphilis is still here. Although not as prevalent in private practice as it formerly was, syphilis is still a problem in psychiatric hospitals. Our attention was focused on the difference between private and institutional practice by a comparison between a survey of private patients and a survey of patients in a psychiatric hospital.

One of us (A.A.) did routine serologic tests for syphilis on a group of private patients dur the years 1946 to 1951. There were 251 white patients thus examined during a five-year period; the number of colored patients was too small to include.

Table 1 gives the age and sex incidence of the patients studied.

TABLE 1.
SEROLOGIC TESTS; PRIVATE PATIENTS

Age Group	Males	Females
1 to 20	6	13
21 to 30	13	38
31 to 40	34	30
41 to 50	34	30
51 to 60	16	14
61 to 70	16	12
71 to 90	2	3
	121	130
Serology:		
Positive	0	0
Negative	121	130

There was one biologic false positive test in a 17-year old female. The rest were negative.

We then reviewed the syphilis status of patients at the New Jersey State Hospital at Greystone Park. The 1953 census indicated that of 6,407 resident patients 222 were diagnosed "neurosyphilis." Furthermore, we found in comparing the year 1953 with 1933 a marked relative decrease in first admissions for neurosyphilis.

TABLE 2.

	1933	1953
Resident Patients	4,150	6,407
First Admissions	1,134	1,464
First Admissions Neurosyphilis	105	23

It would appear that in this area, the attack rate for syphilis has decreased considerably as a result of better diagnostic, epidemiologic and therapeutic procedures. Of course there has been a great advance in therapy in the last ten years and the widespread use of antibiotics for non syphilitic infection will probably reflect itself in greater reduction of syphilis in the future.

*Developed from an exhibit presented at the 1955 Annual Meeting of The Medical Society of New Jersey.

As part of our survey of the syphilitic population of the New Jersey State Hospital at Greystone Park, the patients were examined for evidence of cardiovascular disease and the results are reflected in Table 3.

Summarizing Table 3, it becomes evident that there were 222 patients with neurosyphilis, 113 had cardiovascular syphilis; nine had hypertension alone.

In view of this number of patients with syphilis of the nervous and cardiovascular systems in a single institution, we would like to call attention to this continuing problem and repeat that "Syphilis is still here."

TABLE 3.

Sex-Color	Patients	Without Heart Disease	Hypertension Only	Syphilis plus Cardiovascular Disease
Male white	126	55	6	65
Female white	44	19	2	23
Male colored	34	16	1	17
Female colored	18	10	0	8
	222	100	9	113

The State Hospital

Placebos Too Potent?

Can placebos be too potent? "Yes" says Dr. Henry K. Beecher, writing in the Journal of the American Medical Association (Dec. 24, 1955). In a survey he found that placebos provoked such side effects as dry mouth, nausea, sensation of heaviness, headache, difficulty in concentrating, drowsiness, warm glow, relaxation, fatigue, sleepiness, skin rash, and abdominal pain.

It is doubtful that the placebos produce these through chemical effect. Rather it appears that the physical change was associated with a psychologic reaction to suffering.

Dr. Beecher found that the severer the disease state the greater is the effect of placebos, both in giving relief to pain and in producing side effects.

Decided improvement, interpreted as real therapeutic effect, occurred in 35 per cent of the patients given placebos in each of the studies. The relative constancy of the placebo effect suggests that "a fundamental mechanism" is operating in all these patients.

Which Iron Compound is Best?

O'Sullivan, Higgins and Wilkinson (Sept. 3, 1955 *Lancet* 249:482) made a therapeutic comparison of four common iron compounds. They limited themselves to oral preparations. The drugs studied were ferric hydroxide, ferrous sulphate, a ferrous succinate, and ferrous gluconate in daily 210 mg. doses (of iron) to 80 patients. Ferric hydroxide was found to be unsatisfactory; the three other preparations produced almost equal and satisfactory hematologic responses.

Patients refractory to one oral preparation were refractory to all when given by the same route. Success, however, was achieved with parenteral iron.

Ferrous sulphate could not be tolerated by 13 per cent, and ferrous succinate and gluconate by 4 per cent of the patients.

Ferrous sulphate was found to be effective in smaller doses (210 mg.) than are generally used today.

Since ferrous sulphate is much cheaper than the other preparations and equally efficacious, its use would seem to be indicated.

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Bilateral Adrenalectomy for Metastatic Breast Carcinoma*

Bilateral total adrenalectomy proved to be a worthwhile procedure in two of three patients with metastatic breast carcinoma. In such conditions, there is little danger of harm. Dr. Parsonnet discusses here the theory and practice of this procedure.

FORMERLY, metastatic carcinoma of the breast was considered hopeless. But it now appears that such patients may derive benefit from bilateral total adrenalectomy. On occasion, improvement may be dramatic.

Huggins [1] recently reported 100 consecutive cases of metastatic breast carcinoma treated with total adrenalectomy. All showed objective and subjective evidence of metastases that failed to respond to radiation, hormonal and other therapy. Operative mortality in this series was 5 per cent. Of the remaining 95 patients, 40 per cent showed considerable improvement of one kind or another consisting variously of the disappearance of local recurrences and cancerous ulcers, regression of pulmonary and pleural lesions, involution of lymph glands, and healing of pathologic fractures and osteolytic defects, and subjectively, of a sense of well being, increased appetite and disappearance of intractable bone pain and respiratory symptoms. Galante [2] had similar results in a series of 31 cases.

An attempt was made by these and other authors to analyze their experiences so as to determine the type of patient most likely to benefit by total adrenalectomy. This analysis should eventually lead to criteria for the selection of patients. It might bring about a higher ratio of favorable results and greater predictability in individual cases.

In the light of present experience the following factors are considered germane to the selection of patients for bilateral total adrenalectomy:

(1) *Rapidity of growth.* The greater the time interval between mastectomy and appearance of distant metastases, the better the response to adrenalectomy. If the interval is less than a year, results are poor.

(2) *Age.* Patients under 40 respond least well.

(3) *Tumor differentiation.* Huggins [1] found that most favorable results were in patients whose primary lesion was a well differentiated adenocarcinoma. Undifferentiated carcinoma had the poorest prognosis. However, in Galante's series,[2] adenocarcinoma was favored only slightly over undifferentiated carcinoma.

(4) *Estrogen dependence of metastases.* Huggins [1] says that many patients with metastatic breast carcinoma have an abnormally high excretion of urinary estrogens. Patients in whom this is the case appear to respond better to adrenalectomy. For example, in Huggins series [1] the urinary estrogen titer of unresponsive cases varied from 3.7 to 12.3 IU/24 hours, whereas responsive cases showed a titer of 8.8 to 59.8 IU/24 hours, a level that is, on the average, three times as great. A high estrogen titer may also be inferred if the surviving breast responds to lactogenic stimulation; 500 IU of luteotrophin is given subcutaneously for seven successive days, and, if lactation results, the estrogen level must be abnormally high.

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*From the Department of Surgery, Newark Beth Israel Hospital. Read by invitation to the New Jersey Society of Surgeons, November 9, 1955, Newark, N. J.

In view of all this, it has been stipulated that some breast metastases "depend" on estrogenic substance. This would explain the beneficial effect of castration and suggests a rationale for adrenalectomy since the adrenals produce estrogenic substances. Huggins[1] ascribes excessive estrogen levels in castrated individuals to adrenal activity, and shows, in his series, that such persons are most likely to benefit by adrenalectomy.

Pearson[8] found that some patients with bone metastases have an increased excretion of calcium after the administration of estrogen. He infers that the estrogen causes increased rate of growth of the tumor with further dissolution of bone, and thus demonstrates in another way the "estrogen dependence" of metastases.

In the cases of adrenalectomy reported here, some, but not all, of the above criteria were met. All patients were over 50 years of age. Metastases were noted three to fourteen years after radical mastectomy. In each case the tumor was an undifferentiated or a poorly differentiated carcinoma. None showed estrogenic activity in the vaginal smear, nor could lactation be produced in the remaining breast by the administration of luteotrophic hormone.

CASE ONE

This 67-year old female was admitted with severe pain in the right hip and knee. She was unable to lie on her right side because of aggravation of pain. There was similar pain at rest in the left hip and inability to flex the left knee freely because of pain. Walking with crutches was almost impossible because of pain.

In 1940 a right radical mastectomy had been performed for undifferentiated carcinoma. Symptoms of metastases occurred for the first time in March, 1954 when she sustained a pathologic fracture of the neck of the right femur. This was treated by open reduction. Biopsy at the fracture site revealed undifferentiated carcinoma. In November, 1954 she sustained another pathologic fracture in the shaft of the right femur below the entrance of the Smith Peterson nail. This was treated by open reduction and internal fixation. Since that time bone pain increased rapidly and was present at rest.

The patient was post-menopausal. She had radiation therapy to the pelvis and three courses of testosterone without relief of symptoms. At admission, she was in moderate distress from bone pain and showed signs of recent weight loss. Pain was elicited on motion of both hips and knees, with limitation of motion in all directions. Pressure on the iliac crests caused increase in pain.

X-ray of the bones revealed extensive osteolytic metastases of the skull, ribs, pelvis and both femurs. Vaginal smear was negative for estrogen activity. An attempt to produce lactation in the remaining breast with luteotrophic hormone was not successful.

On February 28, 1955 a one stage bilateral total adrenalectomy was performed. The adrenal glands were free of tumor. The postoperative course was complicated by mild paralytic ileus which subsided in 10 days, and by a wound abscess. Pain completely disappeared within two weeks of the operation.

Eight months after the operation, the patient was completely asymptomatic. She walked without crutches and resumed her normal activities. X-ray of the bones revealed an increase in the translucency of some of the osteolytic lesions and moderate resolution of the lesions of the calvaria. All laboratory data were within normal limits. She had gained 22 pounds. She was maintained on Meticorten® (Schering)* 10 milligrams daily and desoxycorticosterone trimethyl acetate (DCTMA) 25 milligrams every 28 days. For two months she was maintained on cortisone alone but was troubled by persistent headache until it was changed to Meticorten® and DCTMA.

CASE TWO

This 58-year old white female was admitted complaining of difficulty in moving her right arm, a sense of stiffness of the chest in respiration, and troublesome weeping of an ulcer of her right chest wall.

In 1948 a right radical mastectomy had been done for poorly differentiated carcinoma. In 1951 skin metastases developed, primarily at the operative site, but also over the trunk. Since then she had been treated with extensive local radiation therapy and testosterone. The hormonal therapy produced marked hirsutism and, after the first few courses when some regression was seen, was ineffectual. She was post-menopausal. No oophorectomy or pelvic radiation was performed.

She was in no acute distress, but extensive skin metastases were present over the right chest, epigastrium, axilla, supraclavicular skin and left breast. The entire back was studded with tumor nodules. Large lymph nodes were present in the right axilla and right supraclavicular area. Vaginal smears revealed no evidence of estrogen activity. X-ray showed "possible osseous metastases of the skull, and possible left pulmonary metastases."

On March 2, 1955 a one stage bilateral total adrenalectomy was done. The adrenals were free of tumor. Postoperative course was complicated by a bout of congestive heart failure that responded readily to the usual therapy. On the tenth postoperative day, definite softening of the tumor nodules was noted. Regression progressed very rapidly so that six weeks postoperatively most of the tumor nodules had completely disappeared. (See illustrations)

Eight months postoperatively, she was entirely

*Meticorten and Meticortelone were supplied through the courtesy of Schering Corporation, Bloomfield, New Jersey.

free of visible or palpable tumor. All lymph nodes had receded and were no longer palpable. The ulcerated area on the chest was healed. Motion of the right arm was free and painless. The patient felt perfectly well and planned to return to work for the first time in four years. She was well maintained on cortisone 37.5 milligrams daily and DCTMA 25 milligrams every 28 days. For a period of six weeks she had been maintained on Meticorten® and desoxycorticosterone. Although maintenance was satisfactory on this regimen, such large doses of the latter were required to prevent sodium loss, that it was advisable to return to the cortisone regime.

CASE THREE

This 52-year old female was admitted complaining of excruciating pain in the neck, head and left leg for six months. The pain was so severe that she could not be moved without sedation and required continual narcotics.

In 1947 a right radical mastectomy had been done for poorly differentiated carcinoma of the breast. She remained symptom free until 1952 at which time bone metastases became symptomatic. Since that time, osseous spread had increased until practically every bone in the body had been invaded. The calvaria and brain were also involved, associated with paresis of the right third, seventh, ninth and twelfth cranial nerves.

Hysterectomy and bilateral oophorectomy had been performed prior to noticing the breast tumor. Therapy since the onset of symptoms from metastases consisted of radiation, testosterone to the point of marked hirsutism and radio-active phosphorus, all without demonstrable benefit. On admission, we saw an obese woman, lying immobile, in obvious distress and crying out in pain from every movement. Hirsutism of the entire body was marked. Musculo-skeletal examination revealed bone tenderness to light palpation, especially over the thigh. The left leg was shortened, held in eversion and angulated laterally at mid thigh. Neurologic examination revealed involvement of the right third, seventh, ninth and twelfth cranial nerves. There was no papilledema.

Vaginal smears did not show evidence of estrogen activity, and an attempt to produce lactation in the remaining breast with luteotrophic hormone was unsuccessful.

X-ray revealed diffuse osteolytic metastases with a pathologic fracture and dissolution of the upper third of the left femur.

On March 21, 1955 a one stage bilateral total adrenalectomy was performed. The adrenal glands were free of tumor. Her immediate postoperative condition was precarious and her blood pressure was maintained with norepinephrin for the first 24 hours. Thereafter she improved gradually, until May 1 when, for the first time, she could be moved without pain. She remained pain free until June,



Illustration No. 1.—Case 2 preoperatively. Note extensive skin metastases and large ulcerated area on right anterior chest wall.

when severe occipital headaches returned. Four months postoperatively she was again free of pain. The fracture of the femur healed and she could be taken from bed on occasion. The overall postoperative course, however, was far from smooth. She suffered severe recurrent depressions, occasional head and neck pain and three Addisonian crises precipitated by experimentation with her maintenance medication. Despite these occurrences, her condition four months postoperatively was better than prior to surgery. Clear-cut regression of tumor was not demonstrated. I last saw her seven months after operation. She was being maintained on 10 milligrams of Meticortelone® and 3 milligrams of desoxycorticosterone. She had been carried for six weeks on cortisone or Meticorten® respectively, the former with 1 milligram of desoxycorticosterone, the latter with 4 milligrams. She fared best on Meticorten® or Meticortelone® and poorly on cortisone. Cortisone therapy was accompanied by psychotic episodes and a tendency toward fluid retention.

The subjective improvement in these three patients and the remarkable regression of tumor in one of them raises several questions. It has been known for some time that castration of premenopausal women with metastatic breast carcinoma may lead to regression of tumors and subjective improvement. The adrenals, too, produce estrogens, at times in excessive amounts. In these cases, patients may even experience hot flushes after adrenalectomy. It may be inferred from the work of Huggins [1] and others [3-5] that the beneficial effect of adrenalectomy may be due to the elimination of this source of estrogens.

However, in this series of three cases, excessive estrogen levels could not be demonstrated. Vaginal smears were senile. Lactation could not be induced, and adrenalectomy produced none of the typical symptoms of sudden estrogen withdrawal. It would seem, therefore, that "estrogen dependence" is *not* the sole factor involved, and that a high estrogen level is an equivocal criterion for surgery.

Similarly, good tumor differentiation does not appear to be a constant prerequisite for satisfactory results. In Huggins' series,[1] patients with undifferentiated carcinoma showed



Illustration No. 2—Same patient as other illustration, 7½ months postoperatively. The remaining discoloration on the right chest wall is due to superficial telangiectases, not tumor masses.

uniformly poor response to adrenalectomy. Galante,[2] however, had several such cases with dramatic improvement, although as a rule, patients with adenocarcinoma did better. Our own three cases were all undifferentiated or poorly differentiated carcinomas and results were gratifying.

Little can be proved by this short series with respect to the indications for surgery in patients with metastatic mammary cancer. It is clear, however, that tumor differentiation and "estrogen dependence" are *not* strong points for or against surgery.

Our experience in case 3 suggests a contraindication to surgery; the presence of such extensive metastases that rehabilitation would be impossible even if all the known metastatic nodules were to regress. Such would be the case with extensive spinal cord or cerebral metastases and perhaps with such extensive osseous destruction of the spine or long bones that union would be inconceivable. A prolonged life may be far from a blessing to such a patient.

Maintenance therapy is an individual problem. In these cases, cortisone, Meticorten® and Meticortelone® were used with varying doses of desoxycorticosterone. One form of therapy may prove to be better than another in an individual case. At present, therapy is largely a matter of experimentation. The most reliable criteria for control were clinical evaluation, blood pressure, fasting blood sugar, weight and whole blood volume. In this series the patients were followed with extensive laboratory studies including sodium and potassium balance, 17-ketosteroid excretion, serum electrolytes, eosinophil counts, sedimentation rate, water tolerance and routine laboratory studies. Results of these tests either did not reflect the adequacy of maintenance therapy or were too cumbersome for practical use.

SUMMARY AND CONCLUSIONS

1. Three patients with advanced metastatic mammary cancer were subjected to one stage bilateral total adrenalectomy.

2. Sustained gratifying results were obtained in two patients. In one of these, complete regression of all demonstrable tumor occurred. In the third case, relief of pain was obtained for two months. Tumor growth probably continued although apparently at a slower rate.

3. "Estrogen dependence" was not demonstrated in any case. In each case the tumor was undifferentiated or poorly differentiated. These factors apparently were *not* significant prognostic features in the selection of cases for surgery.

4. It is suggested that cerebral or spinal cord metastases may be a contraindication to adrenalectomy because of the tremendous problem of rehabilitation.

ADDENDUM

Since this paper was submitted for publication, patient No. 3 died 7½ months following surgery as a result of extensive osseous metastases with almost complete replacement of the marrow. Two Grams of adrenal gland remained on the left side. Two 4-day intravenous ACTH tests did not reveal increase in 17 ketosteroid excretion that would indicate remaining adrenal tissue. It is possible that the lack of a better remission in this patient was due to the presence of remaining adrenal—V. P.

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The Recognition of Hemolytic Anemia*

Meeting a problem of anemia or jaundice, the physician tends to think first of biliary disease to account for the jaundice or iron deficiency to explain the anemia. Most of the time he is right. But, as Dr. Epstein here points out, hemolytic anemia ought to be considered, particularly when the jaundice and anemia are combined.

THE terminology of the hemolytic anemias may seem unwieldy, confused, and occasionally garbled. Hemolytic anemia may be acute, chronic, primary, secondary, congenital, acquired, hypersplenic, toxic, or eponymic. In spite of this terminologic chaos, great strides have been made in the clarification of hemolytic mechanisms as well as the therapy of the resultant anemias. For a good gross definition, one may accept the classical description of hemolytic anemia: anemia, jaundice, and reticulocytosis, with or without splenomegaly. Most cases will initially come to the physician's attention for either anemia or jaundice. Cases of anemia and jaundice which seemingly have no real pattern, which cannot be adequately classified, and which do not respond to therapy, often come to the attention of the internist or clinical hematologist for further clarification. Usually, however, it is the lack of response to therapy that arouses the earliest suspicion.

In attempting to establish a diagnosis, the practitioner must explore these possible historical factors:

1. Age
2. Race
3. Nationality
4. Drug ingestion
5. Transfusion
6. Recent immunization
7. Family history of anemia
8. Family history of jaundice
9. Recurrent jaundice
10. Recent respiratory disease
11. Difficulty in blood typing
12. Syphilis

Depending on the etiology of the hemolytic process, physical examination may reveal one or more of these findings:

1. Pallor
2. Jaundice
3. Splenomegaly
4. Hepatomegaly
5. Lymphadenopathy
6. Purpura
7. Ulcerative pharyngitis
8. Leg ulcer
9. Gross skeletal deformity

Although the practitioner may clinically suspect the presence of hemolysis, he must depend upon the laboratory for final proof. Procedures of great value in confirming clinical impressions may include:

1. Complete blood count
2. Platelet count
3. Reticulocyte count
4. Icterus index or serum bilirubin
5. Fragility test
6. Sickle cell test
7. Bone marrow aspiration
8. Fecal urobilinogen
9. Coombs test
10. Trypsinized red cell test
11. Circulating agglutinins
12. Circulating hemolysins
13. Erythrocyte survival tests
    a. Differential RBC agglutination
    b. Radioisotope tagged RBC

*Read April 19, 1955, before The Section on Medicine, 189th Annual Meeting of The Medical Society of New Jersey.

The following markedly abbreviated cases are illustrative of specific types of hemolytic anemia.

CASE ONE

A healthy, 21-year old male sustained injury to his leg. Upon admission to the hospital, it was noted that he was somewhat icteric. Physical examination revealed splenomegaly. Of the many laboratory studies performed, significant defects in the following were noted; slight to moderate anemia, reticulocytosis, elevated serum bilirubin especially indirect acting, the presence of microspherocytes in the peripheral smear, as well as evidence of increased hemolysis by fragility test. Bone marrow aspirate revealed increased erythropoietic activity. The diagnosis of congenital hemolytic anemia was thus established, and the spleen removed. After this, all these abnormalities were corrected except the presence of microspherocytes.

CASE TWO

An 18-year old male came under medical surveillance because of a brief history of anorexia, nausea, dark urine, light stool, and jaundice. Clinical evaluation revealed a classic infectious hepatitis. Following therapy there was a gradual improvement in hepatocellular function to the point where all studies were normal except the serum bilirubin, which was persistently elevated to 2 milligrams. Further studies of the peripheral blood showed an occasional normoblast in association with many target cells. There was slight reticulocytosis, and the bone marrow aspirate revealed increased erythropoietic activity. Red cell fragility was decreased. A diagnosis of thalassemia minor was established, and the patient was discharged on no therapy.

These two cases are typical of congenital hemolytic anemia. These basically healthy young men went many years with their hemolytic processes undetected. It is interesting to note at this time, that as in these cases, congenital hemolysis is often an incidental finding.

CASE THREE

A 58-year old male presented himself because of angina pectoris in association with pallor, weakness, and easy fatigability. Physical examination confirmed the pallor, and elicited jaundice with splenomegaly. The laboratory reported normocytic normochromic anemia moderate to severe, leukopenia with granulocytopenia, and thrombocytopenia. An occasional promyelocyte, myelocyte, and metamyelocyte were noted in the peripheral smear. The bone marrow aspirate showed greatly increased activity in both the erythrocyte and granulocyte series, with suspected maturation arrest. A tentative diagnosis of leukemia, myelogenous, aleukemic, was made, but idiopathic pancytopenia (hypersplenism) could not be excluded. The patient was treated with blood transfusion, and this was followed up with urethane. He required about a liter of whole blood by transfusion every month. Repeated examination of the peripheral blood revealed an increasing number of immature granulocytes. Reexamination of the bone marrow showed a more definite myelogenous leukemia, but evidence of erythrocyte maturation arrest persisted at the erythroblast level. Because of an increasing need for blood in association with the bone marrow findings, splenectomy was done. Blood transfusion was not needed for 8 months thereafter even though the chronic myelogenous leukemia progressed as expected.

Although the basic leukemia advanced in this patient, the recognition of hemolysis in the form of hypersplenism with subsequent splenectomy, made overall management much simpler.

CASE FOUR

A 64-year old male had an undiagnosed anemia of 3 years' duration. He had been extensively studied but no diagnosis was established. Therapy for the anemia had been manifold and completely unsuccessful. Blood transfusion was the only means of maintaining his well being. The diagnosis had been primary refractory anemia. Reexamination revealed persistent reticulocytosis of 3 to 6 per cent. All the routine studies for hemolytic anemia remained negative otherwise. Because of the strong suspicion that hemolysis existed in this patient, it was decided that red cell survival be determined. P-32 tagged erythrocytes were used in this study, and a decay curve was obtained by periodically subjecting specimens of his blood to radiation counting. In this fashion, it was noted that there was an increased rate of erythrocytic destruction as compared to a normal control. Having found hemolysis of undetermined cause, the patient was empirically treated with cortisone. No transfusion was needed for a follow-up period of 10 months. Splenectomy is being considered at this time.

This represents the insidious, chronic type of hemolysis so difficult to demonstrate, and which so often resists all forms of therapy. Cases such as this do exist, and as in this instance, are usually called "primary refractory anemia."

CASE FIVE

A 23-year old male reported that his primary medical problem, most of his life, had been warts. He had received every known type of therapy.

usual and unusual, the last being a course of 6 injections of autovaccine prepared from his warts. One day after the last injection, the patient fainted. On arrival at the hospital, he was pale and jaundiced, and had splenomegaly. Erythrocyte count was less than 1 million. Hemoglobin was too low to read, and thrombocytes were nonexistent. The patient could not be typed or cross matched because of agglutination with subsequent hemolysis, in both warm and cold. As a result, he was transfused with Type O Rh negative blood, Witebsky substance added. This was followed immediately by a violent febrile transfusion reaction. Because it was urgent that he receive blood, he was transfused with Type O Rh negative washed, packed erythrocytes. This was tolerated well. Further study after transfusion revealed three hemolytic mechanisms: (1) Abnormal globulin adherent to the patient's erythrocytes as measured by a markedly positive Coombs test; (2) High titers of auto and iso cold agglutinins in the patient's serum; (3) Hypersplenism as manifested by splenomegaly and maturation arrest of all bone marrow elements. Therapy therefore, was directed not only toward a replacement of blood that was being rapidly destroyed, but also toward blocking the abnormal immunologic findings with cortisone, and correction of the hypersplenic state with splenectomy at the proper time.

This is a case of fulminating acute acquired hemolytic anemia. It is assumed because of other features not specifically described here, but to be reported elsewhere, that this process was initiated by the autovaccine injections. Three hemolytic mechanisms, rather than only one, were responsible for the clinical picture presented.

DISCUSSION

JAUNDICE is usually a manifestation of hepatobiliary disease. Most anemias are of the iron deficiency type. These symptoms either singly or in combination, may also be a manifestation of hemolysis. Hemolytic anemia is basically a symptom or a finding, and not truly a diagnosis in most instances. It may be due to a congenital defect of hemoglobin structure, abnormal splenic activity, a symptom of disease such as leukemia, lymphoma, carcinoma, reticuloendotheliosis, or certain types of virus respiratory disease. Treatment, if possible, should be directed toward correction of the primary disease. If this is impossible, the nature of the hemolytic mechanism should be ascertained, and therapy aimed at correcting this abnormality.

SUMMARY

1. A review of the historical, physical, and laboratory aspects of hemolytic anemia is presented.

2. Five illustrative cases met in daily practice are described.

3. It is urged that the physician who meets a problem of anemia, jaundice, or both, consider hemolytic anemia in differential diagnosis.

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Control of Postoperative Nausea and Vomiting With Meclizine*

Dr. Kinney here presents evidence which, provisionally at least, suggests that meclizine (Bonamine®) is helpful in reducing postoperative nausea and vomiting. The statistics do not appear to have been submitted to mathematical analysis to determine the extent to which the differences might be due to chance; but a strong prima facie case is certainly made out.

No satisfactory treatment has been available to control the variously caused anorexia, nausea, and vomiting that are responsible for so much human distress. Barbiturates are only partly effective and sedation is often undesirable. The side effects of scopolamine, widely used during World War II in military motion sickness remedies, detract similarly from its effectiveness.

The discovery in 1949 [1] that an antihistamine (dimenhydrinate available as Dramamine®) could effectively prevent motion sickness has stimulated the search for agents to prevent or relieve nausea and vomiting from different causes. Since then, several antihistaminic drugs have been shown to be active against nausea and vomiting, primarily in studies on motion sickness. These have recently been reviewed by Chinn and Smith [2] who suggest that their action is due not to their effect as antihistamines, but to the anticholinergic activity which they all display. Not all antihistamines and not all anticholinergic drugs are effective. The property which determines anti-motion-sickness activity seems to be a centrally mediated anticholinergic effect. Thus anticholinergic drugs which act principally through the peripheral autonomic system are generally ineffective against motion sickness.

Whether these drugs act directly on the medullary emetic center, which is the ultimate target for all emetic volleys,[3] is not known. Presumably they do not because several anti-motion-sickness drugs are unable to suppress vomiting caused by copper sulfate, which is thought to act directly on the emetic center.[3]

These drugs are effective in suppressing vomiting in animals whose vestibular apparatus is non-functional, and vomiting due to causes other than motion. This will be elaborated below. It suggests that the vestibule is not the site of action; but conclusive evidence is lacking.

The site of action of this new class of drugs is thus apparently restricted to a subcortical area of the central nervous system, although its specific location is yet to be defined.

These new anticholinergic drugs effective against motion sickness can also prevent nausea and vomiting from other causes. Some have been reported effective against nausea,

*Meclizine was used in the form of the Pfizer tradenamed Bonamine®. This drug and the placebo tablets were kindly supplied by Pfizer Laboratories of Brooklyn, N. Y.

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vomiting, and vertigo occurring in pregnancy,[4,5] Meniere's syndrome,[6] radiation sickness,[7] cerebral arteriosclerosis,[8] fenestration procedures,[9] hypertension,[10] and electroshock therapy.[11] They have also been used with good effect in the nausea and vomiting associated with the use of certain drugs. Thus, dimenhydrinate† is reported to be a valuable adjunct to streptomycin therapy;[12] it has prevented nausea and vomiting after administration of analgesics, including morphine and similar hypnotics.[13] It is also reported to reduce the incidence of postoperative vomiting.[14]

The present study was undertaken to determine by the use of adequate controls and by the accumulation of a statistically significant amount of data the value of a new antihistamine, meclizine hydrochloride* (Bonamine®), in controlling postoperative nausea and vomiting. Bonamine® has already been demonstrated to be an effective anti-motion-sickness agent.

MATERIALS AND METHODS

A TOTAL of 149 surgical patients in the Harrison S. Martland Medical Center was treated in the present study. Of these 144 are reported here, 5 being excluded on account of incomplete data.

No attempt was made to select patients for this study, but as wide a variety of surgical and anesthetic procedures was sampled as was available in the hospital. The variety of surgical procedures employed in this study is indicated in Table 1. The patients were divided at rundown into two groups of roughly equal size, one group of 76 receiving meclizine* throughout the study, the other group of 68 receiving a placebo preparation of identical appearance.

Although occasionally varied, the standard pre-operative dose was 50 milligrams of meclizine* the evening before surgery, followed by 25 milligrams about two hours before surgery. All patients received 75 milligrams of Bonamine® daily for three days after surgery, administered in three daily doses. The control patients received placebo tablets according to the same regimen.

TABLE 1. OPERATIONS

Operation	Meclizine*	Placebo
Hysterectomy	13	14
Appendectomy	5	13
Salpingo-oophorectomy	6	6
Hernia repair	7	8
Prostatectomy	1	3
Amputation	2	5
Gastrectomy	6	1
Tonsillectomy	7	2
Cholecystectomy	3	1
Plastic repair	2	2
Colostomy	1	2
Dermatologic procedures	2	3
Sigmoid and perineal resections	4	0
Miscellaneous	17	8
	76	68

The tablets of meclizine* or placebo were dispensed in envelopes containing the total dose for each patient, and were identified by code number. The prescription given to each patient was not identified by name until the study was completed. The codings were prepared, in part, by the investigator who eventually administered the drugs. It is believed that this represents a satisfactory approach to the double-blind technic.

In most of the patients studied, the operation was performed under general anesthesia. Inhalant agents were used in 78 per cent,

†Dimenhydrinate is tradenamed by Searle as Dramamine®.

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while other agents and combinations were used in the rest as indicated in Table 2. Nitrous oxide, ether, and oxygen in combination was the most frequently used general anesthetic. Ether alone, or with oxygen, was sometimes administered. Three operations were done under a combination of vinyl ether and regular ether, and in three other cases, sodium thiopental (Pentothal®) was used intravenously, combined with curare.

TABLE 2. ANESTHETIC AGENTS USED

Type of Anesthetic	Meclizine*	Placebo
Inhalation	64	48
Intravenous	5	9
Spinal	2	6
Inhalation and Spinal	1	0
Inhalation and Intravenous	3	5
Local (Procaine)	1	0
	—	—
	76	68

RESULTS

THE results of this investigation were scored in three categories:

A. The patient reported being nauseated at some time during the first three postoperative days. This report was either voluntary or elicited on questioning.

B. The patient vomited once or more during the first three postoperative days. No distinction was made between patients who had one mild episode of emesis on recovering from anesthesia and those who were more severely affected.

C. The patient neither vomited nor reported being nauseated during the first three postoperative days.

Over-all incidence of nausea and vomiting in the patients receiving meclizine* was 23.7 per cent. In the control group, receiving placebos the over-all incidence was 45.6 per cent.

The effectiveness of meclizine* in easing the postoperative period is best seen not in the over-all results but on analysis of the data. The incidence of nausea and vomiting in the controls shows a high correlation with the duration of surgery (Table 3). In operations lasting less than one hour, nausea and vomiting in the controls occurred with a frequency of 31 per cent. The frequency was 51.5 per cent in operations lasting between one and two hours, and 62.5 per cent in operations lasting over two hours. There is very little correlation with surgery duration in the patients given meclizine*. Thus the equivalent frequencies in these patients were 19, 15 and 33 per cent. The incidence of nausea and vomiting is correlated with the type of surgery performed (Table 4).

TABLE 3. DURATION OF SURGERY AND INCIDENCE OF NAUSEA

(Percentage figures in first two lines indicate incidence of nausea or vomiting)

	Duration of Operation		
	Less Than 1 hour	1 to 2 hours	2 plus hours
Patients on placebo	31%	52%	67%
Patients on meclizine*	19%	15%	33%
Reduction of incidence [a]	38%	71%	50%

a This is the measure of the apparent reduction in the incidence of nausea or vomiting effected by the meclizine.*

TABLE 4. SITE OF SURGERY AND INCIDENCE OF NAUSEA

	Operations	
	Involving Body Cavity	Not Involving Body Cavity
Nausea in controls [b]	50%	32%
Nausea in patients getting meclizine* [b]	24%	22%
Reduction of incidence [a]	55%	31%

b Figures in first two lines indicate incidence of nausea in the placebo-receiving and in the drug-receiving groups respectively.

a This is a measure of the apparent reduction in the incidence of nausea effected by the meclizine.*

From a study of the control group it is evident that surgery in the body cavity is associated with a higher rate of nausea and vomiting (55 per cent) than is surgery elsewhere in the body (32 per cent). Meclizine* depresses the incidence of nausea and vomiting unequally in the two groups and is more effective in body cavity surgery, where there is 55 per cent reduction, than in surgery not involving the body cavity, where there is only a 31 per cent reduction.

Study of the anesthetic agents used did not reveal any significant differences in the incidence of nausea and vomiting either with Bonamine® or placebo. This may be due to the preponderant use of ether and nitrous oxide and the insufficient number of cases using other anesthetics. The clinical data are thus valid particularly with respect to the incidence of nausea and vomiting with ether, nitrous oxide, and oxygen anesthesia.

When meclizine* is considered solely as an anti-emetic agent, without regard to its effect on nausea, it is equally effective in operations, involving the body cavity and in other operations, reducing the incidence of vomiting in each category by about 48 per cent from the control values (Table 5). This is of interest in view of the fact that vomiting in controls and in experimental cases was more frequent in body cavity operations (20 per cent) than in other operations (14 per cent).

In terms of length of operations, however, meclizine* had a higher anti-emetic effect in shorter operations than in longer ones (Table 6). In operations lasting less than one hour, meclizine* reduced vomiting by 60 per cent from its incidence in the controls; in operations of one to two hours the reduction was 69 per cent; while in operations exceeding two hours the reduction was only 40 per cent.

TABLE 5. SITE OF SURGERY AND INCIDENCE OF VOMITING

	Operations	
	Involving Body Cavity	Not Involving Body Cavity
Vomiting in controls (incidence)	20%	14%
Vomiting in meclizine* patients	10%	7%
Reduction of incidence by drug	49%	48%

TABLE 6. DURATION AND INCIDENCE OF VOMITING

	Duration of Operation		
	Less Than 1 hour	1 to 2 hours	2 plus hours
Patients on placebo	19%	15%	22%
Patients on meclizine*	8%	5%	13%
Reduction of incidence by drug	60%	67%	40%

COMMENT AND CONCLUSIONS

MECLIZINE* (tradenamed as Bonamine®) is a suppressor of the vomiting reflex and of the symptoms of nausea in patients recovering from surgery under general anesthesia. The present study sheds no light on the mechanisms involved. Diverse stimuli contribute to postoperative nausea and vomiting. Meclizine* suppresses nausea and vomiting differentially in visceral and non-visceral operations so that the incidences are equalized. One interpretation of this might be that the drug is effective in suppressing the component of nausea and vomiting due to visceral stimulation, but is ineffective in suppressing components due to other kinds of trauma, anesthetics and other factors. In this connection it would be of value to know the effectiveness of Bonamine® in suppressing nausea and vomiting due to anesthetic agents alone where there is no surgery. The present study contributes nothing on this point.

In the controls, the incidence of nausea and vomiting increased with lengthening of operation time. This correlation did not develop in patients given the meclizine.* In them, there was no obvious relationship between operation time and nausea and vomiting incidence. The data are in reasonable accord with the view that Bonamine® brought down the incidence of nausea and vomiting to the same base level regardless of the length of the operation.

No conclusions can be drawn from these studies as to the influence of the anesthetic agent on the incidence of nausea and vomiting,

either with controls or with Bonamine®, because of insufficient data on all agents except the nitrous oxide, ether, and oxygen mixture which was used in most of the cases.

SUMMARY

1. The effect of Bonamine® (meclizine) in reducing postoperative nausea and vomiting was studied. A controlled study was made on 144 patients given Bonamine® or placebo by the double-blind technic. A variety of surgical and general anesthetic procedures was sampled.

2. The over-all incidence of postoperative nausea and vomiting in the control cases was 46 per cent, while in patients given Bonamine® the incidence was 24 per cent.

3. The incidence of nausea and vomiting in the controls varied directly with the length of operation and was higher in surgery involving visceral cavities than in other kinds of surgery. The incidence in patients given Bonamine® showed no such marked variation. No conclusions could be drawn concerning the influence of various anesthetic agents on postoperative nausea and vomiting either with control patients or patients receiving the meclizine.*

4. It is concluded that Bonamine® is a suppressor of postoperative nausea and vomiting, and has a potential use in contributing to the comfort and clinical well-being of patients recovering from surgery requiring general anesthesia.

116 Fairmount Avenue

Allergy Course Announced

Announcement is made of an instructional course in allergy at the Hotel New Yorker in New York City on April 15, 16, and 17, 1956. Sponsored by the American College of Allergists, this program runs from 8:00 a.m. to 6:00 p.m. on each of the three days. The tuition is $15 a day and a doctor may take one, two or three days at that rate. For further details arimail the American College of Allergists, Inc., 401 Marquette Bank Building, Minneapolis 2, Minnesota.

Graduate Courses in Internal Medicine

The American College of Physicians has arranged a number of graduate courses in selected subjects in internal medicine during this spring. The courses include cardiology (March 19-23); isotopes (March 19-24 and March 26-31); radiology (April 9-13); medical practice (May 14-18); electrocardiography (June 4-8); and endocrinology (June 8-23).

These courses have varying fees and are given in different parts of the country. For further details write to the American College of Physicians, 4200 Pine Street, Philadelphia 4.

Peripheral Vascular Society

Physicians interested in peripheral vascular diseases—medical and surgical, and particularly those who treat diabetic, arthritic, or geriatric patients—are invited to signify their interest in the formation of a society for peripheral vascular diseases which would concern itself with both medical and surgical problems. Suggestions and opinions may be addressed to Bruce J. Carroll, M.D., 469 West Front Street, Plainfield, N. J.

Leonard Casser, M.D.

Cresskill

Anaphylactoid Purpura Following Penicillin Therapy

The unpretentious individual case report is the basis of all medical literature and medical learning. Here is an example of this genre—a short story, simply told, pointing a moral that all can read.

Reactions to antibiotic therapy are infrequent, especially in children. However, to gain a realistic perspective of the possible hazards, it has been urged that adverse results be reported. I have not attempted a complete survey of the literature, but the Smith and Walker compendium,[1] suggests that purpuric reactions to penicillin therapy are extremely rare, their only reported cases being those cited by Criep and Cohen.[2] For this reason I feel that the case described below is of interest and importance.

A white female infant, eight months old, was admitted to the Englewood Hospital because of severe lassitude, a temperature of 102 and a scattering of raised, firm, purplish maculo-papules. These varied from two to six millimeters in diameter and were present on the anterior portion of the trunk and extremities, chiefly about the legs and thighs. There was no family history of allergy or blood dyscrasia.

The baby had been well except that at the age of one month a pustular folliculitis of the lower abdomen had been treated with Neomycin-Gramicidin® ointment, and at the age of seven months she had been treated with an injection of 300,000 units of procaine penicillin followed 24 hours later by intramuscular Bicillin® 300,000 units because of a purulent conjunctivitis—offending organism undetermined.

One day before hospital admission, she was seen at home in the early morning because of the sudden onset of fever (105° F.). Postnasal mucus was the only physical finding. Because of the sudden onset and the relatively high fever, antibiotic therapy was begun. Accordingly, 300,000 units of procaine penicillin was given intra-muscularly, and a prescription given for oral penicillin, 200,000 units, three times daily.

Later that day she vomited brown mucus, seemed drowsy, and brought her knees up over her abdomen as though in pain. In a short time the purpuric lesions previously described appeared rather suddenly, along with a faint pink macular rash about the trunk. Two small scleral petechiae were present. Her eye grounds were not studied. The parents believed that the first purpuric spot was at the site of a small scratch on the right forearm.

Several days before admission she had been given aspirin and Neo-synephrine® nose drops because of coryza.

Blood study at the time of admission showed a leucocyte count of 20,400 (37 per cent segmented forms, 49 per cent stab forms, 8 per cent juveniles; 4 per cent lymphocytes, 2 per cent myelocytes), red cells: 3.6 million, hemoglobin: 10 Grams. Bleeding time was 1 minute, 55 seconds; coagulation time, 4 minutes, 5 seconds. Urine showed a faint trace of albumin, and 6 white cells per high powered field.

Two days later the white cell count was 15,650 and the hemoglobin 9.4 Grams. Platelet count was 85,000. Two days later the platelets rose to 190,000.

Treatment consisted solely of Cortisone acetate 50 mg. at eight hour intervals, decreasing slowly as improvement was seen; and oral tetracycline 200 mg. daily in divided oral doses.

On the third day of her stay the fever had disappeared, she was active and appeared well. The purpura lessened gradually, and in three weeks

1. Smith, L. W. and Walker, D.: The Penicillin Decade, Arundel Press, Washington, D. C. (1951)

2. Criep, L. H. and Cohen, S. G.: Annals of Internal Medicine, 34:1219 (May) 1951.

had completely disappeared, leaving no residual induration.

While the impression remains that this was an anaphylactoid purpuric reaction to penicillin, caution will be observed with respect to future use of aspirin, Neosynephrine® and other medications; and studies of platelet counts will be continued to rule out the possibility of this "anaphylactoid purpura" masking other purpuric disease.

SUMMARY

A CASE report of anaphylactoid purpura following penicillin is presented to add to the sparse literature on this subject and so further a realistic perspective of the possible hazards involved.

Grateful acknowledgment is made to George Heller, M.D., Englewood, N. J. for extensive aid in consultation on patient and preparation of this paper.

County Road and Hillside Avenue

Prescriptions for Hypodermics

On February 21, 1956, Governor Meyner signed a bill—A-393—which requires that in New Jersey any lay person possessing or desiring to purchase a hypodermic syringe must have a doctor's prescription to prove entitlement. The law declares that: "No person shall sell, furnish, or give to any person or persons other than a duly licensed physician, dentist, veterinarian, undertaker, nurse, podiatrist, registered pharmacist, or a hospital, sanitarium, clinical laboratory or any other medical institution, or a state or governmental agency, or a regular dealer in medical, dental or surgical supplies, or a resident physician or interne of a hospital, sanitarium or other medical institution, an instrument commonly known as a hypodermic syringe, hypodermic needle or any instrument adapted for the use of narcotic drugs by subcutaneous injections without a written prescription of a duly licensed physician, dentist or veterinarian. Such prescription shall contain the name and address of the patient, the description of the instrument prescribed and the number of instruments prescribed.

"Every person who disposes of, or sells, or furnishes, or gives away a hypodermic syringe or a hypodermic needle or an instrument adapted for the use of narcotic drugs by subcutaneous injections, upon the written prescription of a duly licensed physician, dentist, or veterinarian, shall record upon the face of the prescription, over his signature, the date of the sale or furnishing of the instrument. This prescription shall be retained on file for a period of two years and shall be opened to inspection by any public officer or employee engaged in the enforcement of this section. A prescription filed in accordance with this action shall be sufficient authority, without the necessity of a renewal or reissuance, to permit subsequent sales or the furnishing of hypodermic syringes or hypodermic needles or instruments adapted for the use of narcotic drugs by subcutaneous injections to the person to whom the prescription was issued, for a period of 6 months from the date of its original issuance.

"It shall be unlawful for any person or persons, except a duly licensed physician, dentist, veterinarian, nurse, podiatrist, hospital, sanitarium or other medical institution, or a resident physician or interne of a hospital, sanitarium or other medical institution, to have under control or possess, a hypodermic syringe, hypodermic needle or any other instrument adapted for the use of narcotic drugs by subcutaneous injections with intent to use such syringe, needle or instrument for such purpose, unless such possession be obtained upon a valid written prescription from, and such use to be authorized or directed by, a duly licensed physician or veterinarian. For the purposes of this subdivision no such prescription shall be valid, which has been outstanding for more than 6 months.

"Any person who violates any provision of this section is a disorderly person."

The Medical Society of New Jersey recorded itself as approving the purpose of the bill but disapproving of the actual measure because "in seeking to protect the welfare of narcotic addicts it was jeopardizing the welfare of people, such as diabetics, who are dependent upon the possession and use of hypodermic syringes."

Richard A. Hopping, M.D.

East Orange

Management of Ischio-anal Abscess and Fistula in Ano*

Immediate and adequate drainage is the key to the treatment of ischio-anal abscess. Surgery is the only rational approach to fistula in ano. In this practical paper Dr. Hopping discusses the technics involved in a practical and usable manner.

It is foolhardy to proceed to treat an ischio-anal abscess or a fistula in ano, without a thorough personal history, physical examination, sigmoidoscopy and basic laboratory tests. The patient and his family (if at all possible) must be told what has to be done. This is of particular importance in abscesses since he (and they) must be made to understand that drainage of the abscess is only the first of probably two or more procedures which must be done to insure recovery. A thorough explanation and evaluation of the problem at this time will prevent misunderstandings and possibly recriminations later.

ISCHIO-ANAL ABSCESS

Once the diagnosis of ischio-anal abscess has been made, the immediate demand is for adequate and considered drainage. The admonition to await the appearance of fluctuation is not always to be followed before incising the area. Much time has already been used up by the patient during his phase of indecision and home care and by his journey to the office or hospital. Generally speaking, fluid pus under great pressure may be found within three or four days of conscious symptomatology. It is seldom that abscesses are not "ripe" for drainage by the time the diagnosis is made. No disaster is invited when a well-placed, adequate incision is properly if not productively made.

These infections are most frequently due to a mixed bacterial infection. Some of the more versatile antibiotics currently available may be used as adjuncts to the primary surgical approach. These additional tools have appreciably reduced the constitutional reactions, complications, pain and time involved in the resolution of much of the acute tissue reaction. These agents also speed localization. The blind, costly, and indiscriminate use of penicillin is regrettable. Gas bacillus must be considered and treated befittingly but it is fortunately very rare. It is a good rule to make routine cultures and do chemo-therapeutic sensitivity tests on these cultures in all doubtful cases.

Incision and drainage of these abscesses should be guided by three considerations listed in the following order of importance: (1) The complex anatomic features of the area must be fully realized and the incision placed to avoid damage to necessary structures. (2) The drainage incision must be adequate. An area of skin and subcutaneous tissue should be excised on either side of the line of incision to

*Read at the Gastro-Enterology Section, Annual Meeting, The Medical Society of New Jersey, April 18, 1955.

maintain an entirely open drainage route. Regardless of the size of the underlying abscess cavity, it is seldom that these areas of excision of overlying skin should attain a size of more than a 5 centimeter diameter ellipse. Gross debridement of a half or more of a buttock's skin is unnecessary, unscientific, and unparsimonious of the patient's natural resources. The allegation that such wholesale sacrifice of viable and useful integument obviates the necessity of subsequent fistulectomy has been investigated and found to be wanting in accuracy. (3) Incisions should be planned to avoid possible damage later during fistulectomy to the anococcygeus, to the external sphincter muscles, or to the integrity of the the perineal body and its components. This latter is doubly important in females. Damage to musculature and to fascia and nerve elements should be minimized. Distortion occasioned by the tremendous edema attending infection in this area makes accurate recognition of these important landmarks difficult at times. One-stage drainage and fistulectomy operations are best reserved for the infrequent and small subcutaneous perianal abscesses.

The wounds are not packed with gauze. Judicious placement of Penrose drains is of significant value as is early and intelligent postoperative nursing care. The drains maintain free drainage during the first two or three days after surgery. They are infrequently used to help in the introduction of irrigating solution to the abscess cavities. Once drainage is established, it is poor technic to probe, palpate, or otherwise disturb the inflammatory walls of the abscess. Intelligently administered anesthesia is essential. General, spinal, block, or local may be used satisfactorily. Because of the short duration of the procedure, intravenous anesthesia is favored. Good nursing conspicuously reduces the postoperative morbidity period. Profuse, fetid and potentially dangerous drainage is expected for two or more days. During this period, frequent dressing changes, cleansing of nearby soiled areas and other vital nursing procedures are of extreme importance in maintaining the well-being and comfort of the patient. Sedatives can be reduced to a minimum. Rapid rehabilitation of the patient to complete self-sufficiency is the goal of good medicine and a tribute to good nursing.

After drainage is afforded, it is always surprising and highly satisfying to observe the speed with which healing takes place. Compared with the course of acute infections elsewhere, it is almost supernatural to observe the speed of resolution of symptoms and the rapidity of repair that does occur with good care of acute ischio-anal abscesses. Irrigations of the suppurative cavities are only rarely indicated. The drainage from the abscess cavity rapidly assumes a serous and clear appearance, diminishes rapidly in quantity and a minimum of fine, clear, healthy, granulation tissue appears. The speed with which the acute, then subacute phase resolves is variable, but with good drainage, progressive and satisfactory. The end point of healing and resolution of the abscess is reached when the stage of chronic fistula in ano is reached.

ANAL FISTULA

A FISTULA in ano is composed of a simple or branched tube of scar tissue lined with granulations. The tube extends from the primary opening in the low rectum, most usually at a crypt in the midline posteriorly at the dentate line, to one or more secondary openings elsewhere. When evidence of infection is reduced to a minimum, the time for surgical intervention to cure the condition is at hand. Anything other than surgical approach to the problem of care of fistula in ano is irrational and is to be condemned.

Fistulotomy, not fistulectomy is the procedure of choice in the average situation. Fistulotomy involves considered incision of the entire tract and all its ramifications; saucerization of the wounds and institution of all measures possible to expedite rapid, progressive, comfortable, convalescence and permanent healing of the wounds. Saucerization involves beveling the sides of the finished incisions so that none are perpendicular to the surface epithelium but slope gradually to the depths of the wound where the sides and base of the fistu-

lous tube are located. The use of suture material is minimized. In most cases it is only used for the control of bleeding. Occasionally, suturing also may be employed to close partly or otherwise modify some of the physical defects produced during surgery. When suture is employed with these objects in mind the hazards involved must be appreciated and postoperative care must be enlarged and modified in an attempt to anticipate and avoid possible complications.

The contraindications for surgical repair of a fistula are infrequently found but are absolute. These conditions are: intractible diarrhea, ulcerative colitis, regional enteritis and a proximal malignancy. Massive involvement, extensiveness, or multiplicity of tracts are not factors for consideration in evaluating operability. Generally speaking, the use of a seton is not encouraged although there is undoubtedly a place for such a tool. It is perhaps only a personal suspicion, but only rarely is a seton or postoperative packing of fistulotomy wounds employed because of a persistent belief that such foreign bodies in an otherwise clean and rapidly healing wound encourage the production of excessive amounts of granulation tissue which later leads to inordinately heavy scarring. The latter is to be avoided since it interferes materially with sphincteric function.

Methylene blue solution to aid in the delineation of the ramifications of a fisutla's branching tube is not encouraged for many reasons. It cannot be controlled. The tracts themselves are, for the most part, well defined, and the dye can obscure otherwise normal tissues. Most frequently the course of the fistulous tracts through the sphincter muscles is at right angles to the long axis of the muscle fibers. Even if this fortunate circumstance does not obtain, it is good policy to incise the tract directly regardless of its position or course through the muscle fibers. Incontinence does not result from the somewhat unorthodox approach.

The postoperative management of fistulotomy wounds is as important as the surgery. Negligent postoperative care can undo good surgery and frequently results in an uncomfortable and uncooperative patient with a "recurrent" fistula, a contracted anus, or an incontinent sphincter — possibly all three.

A fistulotomy wound heals by secondary intention. If the wound is kept clean, dry, and exposed to air, it will close rapidly with a minmum of granulations and a very modest scar will result. The wounds are cleansed mechanically by irrigations and spraying. Both are started as soon as tolerated, usually within twenty-four hours after surgery. Irrigations are done with a syringe several times a day. Between cleansing procedures the wound is maintained in as dry a condition as possible. A favored dressing is a small tuft of cotton gently tucked into the anal verge. This absorbs drainage from the open wound and also serves to keep the buttocks somewhat separated. Patients are instructed in the placement of these "cotton tails" and are encouraged to replace frequently. Ambulation is encouraged at an early hour and as soon as possible thereafter the patient is instructed in the use of a bidet.†

A bath spray attached to a bath tub faucet has been found to make an excellent substitue for a bidet† and is used in hospitals and patients' homes not so equipped. The postoperative patient quickly discovers the great comfort imparted by the frequent use of such a spray on his wound and is likely to make a nuisance of himself by "hogging" the bathroom facilities to the exclusion of his neighbors. A normal bowel habit is encouraged within four days of surgery and is maintained. Mineral oil is not used as a laxative. Grenz ray and infra red exposures have been used to encourage healing in specific cases. No great benefit has been demonstrated from these measures.

During the period of healing it is of paramount importance that the wounds be observed daily. Only by continuous contact can the many annoying problems arising during this period be minimized or arrested. Rewarding indeed is the prompt, clean, healing that results from meticulous care.

†A Sitz bath.

144 South Harrison Street

Alvin A. Rosenberg, M.D.
Morristown

The Treatment of Shock in Acute Myocardial Infarction

Pressor drugs are recommended for shock due to myocardial infarction if there is neither pulmonary edema nor elevation of venous pressure. Also discussed are the roles of whole blood, plasma expander, digitalization, transfusion and diuretics

An important cause of death within the first 48 hours after coronary thrombosis is profound hypotension and the development of shock. This occurs in about 10 per cent of all cases of myocardial infarction and is associated with a mortality rate of 80 to 90 per cent. Since the total mortality rate following acute myocardial infarction is 20 per cent, the shock state occurs in 40 to 45 per cent of those patients who die.[1]

Griffith, *et al.*[2] consider the shock state to exist when marked hypotension, lasting for an hour or longer, is accompanied by signs of peripheral circulatory collapse. In a patient whose blood pressure has previously been within normal limits, a systolic blood pressure reading of 80 or below is accepted as evidence of shock. In the formerly hypertensive patient, a systolic blood pressure of 100 or below evidences shock.

Shock in myocardial infarction is a manifestation of forward heart failure due to depletion of a significant portion of the ischemic ventricular myocardium within a few minutes, thereby throwing the burden of ventricular work on the remaining muscle. Other factors include excessive sedation, cardiogenic reflexes, acidosis, arrhythmias with rapid ventricular rates, hemorrhage, and concomitant intravascular thrombosis.

The aim of therapy is to restore the effective head of blood pressure in the aorta in order to perfuse adequately the coronary, cerebral, renal, hepatic, and other vital circulations. As far as the heart is concerned, elevation of the blood pressure to 100 systolic in previously normatensive patients and to 120 in those previously hypertensive, improves the total coronary circulation, enhances the chances of survival of borderline myocardium and that supplied by stenotic arteries, and may decrease the size of the infarct.

The treatment of shock in acute myocardial infarction may be divided into routine measures and more specific ones to be be taken when the shock is more severe or the routine procedures have failed. The routine measures used in the treatment of shock consist of :

1. Relief of pain and anxiety by parenteral administation of morphine, levorphan tartrate† or meperidine hydrochloride.* Morphine ⅛ to ¼ grain in 2 milliliters of water is best given intravenously and often effects a prompt pressor effect.

†I use the Hoffmann-La Roche Levo-Dromoran tartrate.
*Meperidine is available under the Winthrop-Stearns tradename of Demerol.

1. Hellerstein, H. K. and Brofman, B. L.: "The Treatment of the Hypotensive State Accompanying Myocardial Infarction," Mod. Concepts of Cardiovascular Disease 20:104 (1951)

2. Griffith, G. C., Wallace, W. B., Cochran, B., Jr., Nerlich, W. E. and Frasher, W. G.: "The Treatment of Shock Associated with Myocardial Infarction," Circulation 9:527 (1954)

2. Rapid ventricular rates should be promptly diagnosed and swiftly treated.

3. Anticoagulant therapy should be quickly started with intravenous heparin.

4. Congestive heart failure, pulmonary edema, anoxia, and other complications contributing to shock are treated as expeditiously as possible.

5. Miscellaneous measures such as good nursing care, lowering the head of the bed if possible, bandaging the extremities, reassurance, and supportive drugs such as caffeine are auxiliary measures of value.

If these measures do not quickly relieve the shock, the following specific therapy should be instituted without delay. The earlier shock is treated in myocardial infarction, the quicker the response and the less the danger of its becoming irreversible.

1. *Vasopressor Drugs*: Norepinephrine has been used without untoward effects on ventricular irritability and is effective early in shock, or when employed late in the treatment after other amines have failed. Gazes, *et al.*[3] found that norepinephrine produced pronounced increments in heart contractile force, in addition to pressor effects, in unanesthetized trained dogs. The contractile force increments were of similar magnitude to those produced by epinephrine. Phenylephrine (as Winthrop-Stearns Neosynephrine) was found to be predominantly a pressor amine, producing only minimal changes in heart contractile force. They feel that the effect on contractile force of the heart of norepinephrine is a basis for the high recovery rate observed with this amine in the treatment of shock accompanying myocardial infarction, particularly in those cases associated with congestive heart failure. Norepinephrine is not contra-indicated by the presence of pulmonary edema. It is administered as follows:

Two vials of 4 milligrams each are added to 1000 milliliter 5 per cent glucose in water or other suitable infusion fluid, and the solution is given by intravenous drip through a polyethylene tube introduced for a distance of 6 inches into the antecubital vein. This is double the amount of norepinephrine ordinarily recommended, but even stronger solutions containing up to 32 milligrams per liter have been used,[4] if a pressor response is not obtained and the rate of administration has to be slow because of the presence of pulmonary edema, or the desire not to overload the blood volume and perhaps initiate pulmonary congestion. If the patient is dehydrated and a more rapid rate of administration of fluid is desired, 2 to 4 milligrams of norepinephrine per liter may be used. One should try to obtain a pressor response at a rate of flow not greater than 40 drops per minute. It is important to avoid extravasation of the fluid into the subcutaneous tissues. A patient recently treated developed an extensive slough because of such leakage.

The intravenous drip is begun at 10 drops per minute and increased or slowed, or stronger solutions used in the effort to raise the blood pressure to 100 or 120. The drip is continued for as long as necessary, taking the blood pressure every minute for the first 30 minutes, every 15 minutes for the next three hours, and every 30 minutes for the remaining period of therapy. When discontinuance is contemplated a trial on lower dosage is attempted, followed by an infusion containing no norepinephrine; this is continued for several hours in order to permit rapid resumption of the pressor therapy if shock should return.

Isopropylnorepinephrine (Isuprel®) is particularly useful in cases of shock associated with complete heart block, bundle branch block or prolonged congestive failure. Although its action in coronary shock has not been definitely established, it strengthens and speeds up the heart beat, effects which are presumably accompanied by medullary stimulation, coronary dilation, and relief from excessive peripheral vasoconstriction.[2] Two or three milligrams of isopropylnorepinephrine are given slowly intravenously followed by 7.5 to 15 milligrams given under the tongue as needed after shock has been overcome (at 10, 15, or 30 minute intervals).

Epinephrine, ephedrine, Mephentermine® or Neosynephrine® may also be used for a pressor effect, but for various reasons are not as satisfactory as the drugs mentioned above.

2. *Blood, Plasma, or Plasma Expanders*: Intravenous administration of these agents is effective if given early and if venous pressure is not high. Because of the effectiveness of norepinephrine there is less use for blood or plasma in combatting shock. Blood is preferable if anemia is present, and plasma or plasma expander if hemoconcentration is present. Be-

3. Gazes, P. C., Goldberg, L. I. and Darby, T. D.: "Heart Force Effect of Sympathominetic Amines as a Basis for Their Use in Shock Accompanying Myocardial Infarction," Circulation 8:883 (1953)

4. Sampson, J. J. and Zipser, A.: "Norepinephrine in Shock Following Myocardial Infarction. Influence Upon Survival Rate and Renal Function," Circulation 9:38 (1954)

cause of the fear of homologous serum jaundice, the use of a plasma expander such as dextran is preferred: It is less expensive, has no hepatitis virus, and is protein-free. It is now carried in our ambulance instead of plasma. I tried to prevent homologous serum jaundice due to plasma by use of immune globulin, but the attempt was unsuccessful. The blood or dextran may be given at a rate of 2 to 4 milliliters per minute with an average of 200 milliliters per hour. The infusion is, of course, terminated if pulmonary edema occurs. Blood or plasma is more effective when given with a pressor amine than when used alone.[6]

Retrograde arterial transfusion may be used in severe shock unresponsive to all other measures.[2] Success has been reported by some investigators,[6] but recent reports of gangrene in the extremity used, necessity for cutting down on the artery, and the special apparatus required makes this treatment less desirable for small hospitals than the other methods described. In our hospital the apparatus is available, but has not yet been used for the treatment of shock due to coronary thrombosis.

3. *Digitalis Glycosides*: The use of the rapidly acting ones such as strophanthin, ouabain. Digoxin,® and Cedilanid® is valid in shock, since there is evidence of congestive heart failure even in patients with predominant signs of shock. Patients in congestive heart failure with elevated venous pressure and shock are, naturally, quickly digitalized. They will also respond satisfactorily at times to norepinephrine pressor therapy alone. If the heart failure is limited to a few basal rales in the lungs, digitalization may not be necessary and pressor amine therapy alone will suffice. If immediate digitalization is desired, one can give 0.25 to 0.50 milligrams of ouabain intravenously in 5 measured minutes, followed by 0.1 milligrams every one-half hour, until 1 milligram has been given or full digitalization is achieved.

4. *Venesection* is used if the patient in shock is in pulmonary edema, which has not responded to digitalis, or 50 per cent ethyl alcohol inhalations,[5] or mercurial diuretics. It may be combined with retrograde arterial transfusion or with pressor amines. The latter will sometimes cause impressive clearing of the lungs as the blood pressure rises and the patient emerges from shock without any treatment directed at the pulmonary edema.[6]

SUMMARY

THE use of the various agents of value in the treatment of shock due to myocardial infarction may be summarized as follows:

1. If the patient is moderately hypotensive, asymptomatic, and without signs of peripheral circulatory collapse, routine therapy is instituted as described.

2. When shock is present, immediate treatment is begun. If there is no elevation of venous pressure and no pulmonary edema, pressor drugs are preferred. If continuous therapy does not sustain the blood pressure above 100 to 120, whole blood or plasma expander (less than 250 cubic centimeters per hour) should be given within an hour of seeing the patient.

3. If shock and congestive heart failure are present, pressor drugs are started followed by rapid digitalization and mercurial diuretics. If the heart failure is very mild, plasma expanders may be given in addition if necessary. Retrograde arterial transfusion may be given in the presence of pulmonary edema after preliminary venesection or alcohol vapor inhalation, but no venous transfusion is prescribed if frank pulmonary edema is present.

4. If shock with rapid ventricular rate is present, treat the rapid rate first before other specific measures are used.

5. Luisada, A. A.: "Therapy of Paroxysmal Pulmonary Edema by Antifoaming Agents," Circulation 2:872 (1950)

6. Gootnick, A. and Knox, F. H., Jr.: "Management of Shock in Acute Myocardial Infarction," Circulation 7:511 (1953)

22 High Street

The Bergen Community Blood Bank*

The Blood Bank Committee of the Bergen County Medical Society here reports its experiences in the implementation of a program which had its inception in 1950 while it was seeking a solution to the problem of inadequate blood procurement and distribution affecting the citizens, the physicians and the hospitals of Bergen County. In this report, we present a plan which evolved from many proposals and compromises, and is now in operation. Such a regional program as outlined by Moolten[1] is well on its way to fulfillment in this region, a rapidly growing, highly industrialized county with a population well in excess of 600,000. Bergen County has four general, voluntary hospitals (all of which have undertaken recent expansion programs) a large county hospital, and two smaller specialized hospitals.

In 1948 only two hospitals in the county had adequate blood bank facilities or made any serious effort to recruit donor replacements and to procure blood in advance of need. About 900 units of blood were being used per month in the seven hospitals of the county. About 15 per cent of this was obtained through credit with the New York Regional Red Cross Blood Bank; about 50 per cent or more was purchased from commercial blood banks in New York City. The remainder were obtained within the county from the usual replacement, volunteer or professional donor sources. Efforts at integration between existing hospital blood banks failed. There was no surplus to be exchanged; more often a deficit existed. The lack of uniformity of technical standards in regard to blood collection and storage was also a hindrance to reciprocal exchange.

Efforts by the hospital administrators in 1948 to enlist the procurement and promotional services of the American National Red Cross and its local chapters came to naught, when serious differences of opinion made a cooperative venture impossible.

The appointment of the Blood Bank Committee of the Bergen County Medical Society in 1949 led to further efforts to create a plan and atmosphere whereby a "permissive" program would be sponsored by the county medical society, with Red Cross chapters cooperating with publicity, clerical assistance and donor procurement. The hospital blood banks were to handle the technical phases. This was approved by the Bergen County Medical Society. However, the Korean War began at that time and the American National Red Cross effort had to be concentrated on the National Blood program for the Department of Defense. No further local "permissive" programs could be authorized.

The Blood Bank Committee was re-activated in 1952 and, with the help of some interested lay people, studied the idea of a centralized blood bank. It was decided that this should be financed independently by the community at large and without solicitation of tax funds. It was to be initiated by the Bergen County Medical Society, and controlled by a Board of Trustees having equal medical and lay representation. It was to be incorporated as a charitable, non-profit institution, self-sustaining from fees kept on a unit-cost basis to be paid by the patient. This represents a true "fee-for-service" involving only the costs of processing the blood. Such a plan is not original, of course, but is basically that of the so-called "Community Blood Bank," a type of organization which has mushroomed nationally from 10 in 1945 to more than 70 in 1955.

The advantages of such a centralized institution are the following:

(1) Satisfactory technical standards are under the control of a single laboratory and professional staff. This permits the obtaining of a National Institutes of Health federal license, thus facilitating exchange and acceptance of blood within the state and across state lines. The location of Bergen County makes this essential.

(2) More efficient methods of blood procurement are created through the organization of advance deposit plans for individuals, families, maternity patients and groups, based on sound actuarial experience.

(3) There is unified control of blood replacement or collection of the replacement and processing fees in lieu of blood. This also brings about the universal encouragement of the fundamental principle of the *responsibility* of blood replacement, as

*Prepared by the Blood Bank Committee of the Bergen County Medical Society.

1. Moolten, Sylvan: Journal of The Med. Soc. of N. J. 52:476 (Sept.) 1955

stated in the "Ludwig Resolution" approved by the American Medical Association in June 1953.[2]

(4) There is better logistical control of blood processing, distribution and storage in all the hospitals of the county. Prompt interchange between hospitals is then a function of the central blood bank, manipulating its own blood as circumstances require.

(5) Establishment of a local "clearing house" function, integrated with those of other regions within the state or elsewhere in the nation. This is proposed by the American Association of Blood Banks and is a natural outgrowth.

(6) There is a greater availability of rarer types of blood than is possible in individual hospital blood banks alone, from a larger population pool, or by the establishment of volunteer and professional donor registries, as may be required.

(7) There is greater economy and efficiency of operation, thus keeping down the over-all cost of blood procurement and processing. This eventually permits a lower unit-cost, the saving being passed along to the patient by the eventual reduction of the processing charge.

(8) Improved public relations relative to donor welfare become more feasible, thus making blood donations a pleasant and safe experience and likely to be repeated by the donor.

(9) The loss from failure of blood replacement, or in cash value as in the case of indigent patients, is easier to absorb in the operation of a larger centralized blood bank.

(10) Wide community interest and support of such community blood banks through lay participation on the Board of Trustees, donor clubs, and volunteer workers promotes the formation of advance credit plans, helps to cut operating expenses, and furnishes a greater esprit de corps.

(11) Uniformity of charges and frequent auditing of accounts permit estimation of the changes in unit-cost and the over-all operating costs. In this way the centralized blood bank may maintain its non-profit status, and publicize its financial statements as indicated.

(12) The collection of large quantities of blood from groups is facilitated by the use of "Bloodmobile" trips, operated by a centralized blood bank in a more efficient and less costly basis than from smaller, individual blood banks. Such quantities may be processed and distributed with less probability of loss from outdating. Such trips also work to the convenience of large donor-groups, thus saving them travel to the central bank.

(13) Civil defense functions are met by the mobilization of blood in times of grave emergencies, through the integration of such emergency blood procurement from a central bank and the affiliated hospitals working together, all drawing from a much wider area.

(14) Such a blood bank is basically a charitable institution, which supplies its commodity on call, regardless of ability to pay or to replace in kind. This should naturally apply to any sort of blood bank, sponsored by or administered by a hospital or other medical agency.

In conformity with the general plan outlined above, a twelve-man Board of Trustees was formed by the Bergen County Medical Society. Six prominent laymen joined with six physicians to form this Board. The plan was approved in 1953 by the Bergen County Medical Society.

The county was divided into six districts, with a lay member of the Board as Chairman in each district. Canvassers were recruited by volunteer "Captains" in each town. A "single-shot" campaign for funds was started in the fall of 1953. This resulted in a capital fund of $90,000. Meanwhile, a 3½ acre site with a building suitable for conversion was purchased for $22,500 in Paramus, N. J.

With the help of volunteer American Federation of Labor workers, architects and contractors, and with building materials and equipment often obtained free or at cost, the building was remodeled for $35,000. An additional $3,000 was spent for grading and a parking lot. Another $10,000 was used to purchase necessary furniture, equipment and supplies. The insured value of the building and equipment was in excess of $100,000. Volunteer labor and services alone were estimated at $12,000. Local C.I.O. units pledged a substantial amount toward the purchase and equipping of a "Bloodmobile." The Junior League of Englewood raised over $3,000. From this, we bought a station wagon for the transportation of blood from the Bergen County Community Blood Bank to the local hospitals.

Many county organizations, including the local Red Cross chapters, furnished volunteers for clerical assistance, donor room, and canteen. In this way expenses have been held to a minimum.

An Acting Medical Director, Dr. H. Preston Price, headed the Technical Committee. Dr. Eugene Katzin, Medical Director of the Essex County Blood Bank, gave freely of his time and advice. An Executive Director, Mr. William E. Upton, Jr., of Aurora, Ill., who had had considerable experience in the administration of blood banks, was the first full time employee. He did yeoman service in expediting the financial campaign for funds, hastening the completion of building operations, planning the initial blood procurement, and setting up the first blood donor groups which now total more than thirty-five. These include industrial, fraternal, church, veteran and service organizations, and also smaller clubs and societies. The municipalities of Washington Township, Leonia, Hasbrouck Heights and

2. Jour. A.M.A. 152:837 (June 27) 1953—A.M.A. Proceedings of the House of Delegates relating to Blood Bank matters. Resolution on Blood Banking, J. Lafe Ludwig, M.D.

River Edge formed groups to cover their entire populations. Individual, Family, Maternity, and Volunteer credit plans have also been put into operation on an insurance or reserve basis. Two experienced laboratory technicians were obtained, along with a secretary and a bookkeeper to complete the present roster of five employees. The building was dedicated on February 22, 1955. Thus, the Bergen Community Blood Bank opened with no income and about $10,000 to cover initial operating expenses. In September 1955, Dr. Julius A. Klosterman was appointed Medical Director, succeeding Dr. Price.

During the first nine months of operation, through December 1955, the Bergen Community Blood Bank has grown steadily. Blood procurement began from Donor Clubs. Most of these have given an extra, small percentage to be credited to indigent patients unable to replace blood on any basis. In this way blood has been made available for patients who have no established advance credit. Replacement of blood for such patients has proceeded slowly, often over a period of weeks, though the ratio of replacement has compared favorably with hospital experience. In lieu of blood replacement the blood may be paid for in full, at $35.00 per unit. If blood is replaced on a one-for-one basis, a fee of $10 is collected for processing. This fee may be cancelled by the donation of an additional unit of blood. The method of payment or of replacement is entirely optional, but replacement is always encouraged. In September 1955 the Bergen Community Blood Bank was able to meet its monthly overhead out of current income. Monthly expenses now average about $3,000.

Amount of blood drawn has progressively increased from 100 to 400 units per month. A total of 3690 units of blood have been drawn as of December 1, 1955. Replacements from the Blood Bank for patients who have credit, and were hospitalized elsewhere, have been sent outside Bergen County to Passaic, Hudson, Essex, Morris, and Union Counties in small quantities. A system of reciprocal exchange credit on a unit-for-unit basis has been temporarily worked out with the New York Regional Red Cross Bank. The Red Cross replaces blood for patients hospitalized in New York City or Rockland County. The Bergen Community Blood Bank replaces Red Cross credits for patients in Bergen County hospitals. The Bergen Community Blood Bank is a member of the American Association of Blood Banks.

1956 ANNUAL MEETING

HADDON HALL, ATLANTIC CITY

Luncheons

MONDAY, MAY 14, 1956—12:30 - 2:00 p.m.

Section on Surgery and New Jersey Chapter of American College of Surgeons
Reservations: James H. Spencer, M.D., 49 High St., Newton; or Salvatore Giordano, M.D., 73 Maple Ave., Morristown

TUESDAY, MAY 15, 1956—12:30 - 2:00 p.m.

New Jersey Allergy Society
Reservations: Herbert W. Diefendorf, M.D., 129 Summit Ave., Summit

Section on Anesthesiology
Reservations: Irving M. Riffin, M.D., 419 Park St., Upper Montclair

New Jersey Ophthalmological Society
Reservations: Henry Abrams, M.D., 253 Witherspoon St., Princeton

Section on Rheumatism
Reservations: Evelyn Z. Merrick, M.D., 273 Tremont Ave., Orange

WEDNESDAY, MAY 16, 1956—12:30 - 2:00 p.m.

Section on Dermatology and New Jersey Dermatological Society
Reservations: Herman Kline, M.D., 2643 Pacific Ave., Atlantic City

Section on General Practice and New Jersey Academy of General Practice
Reservations: Baxter A. Livengood, M.D., 64 Cooper St., Woodbury

Section on Metabolism and Medical Members of New Jersey Diabetes Association
Reservations: Norman L. Murray, M.D., 129 Summit Ave., Summit

Section on Neuropsychiatry
Reservations: Harry H. Brunt, Jr., M.D., Ancora State Hospital, Hammonton; or William Furst, M.D., 50 So. Munn Ave., East Orange

Announcements • • •

Additional Announcements are on pages 114 *and* 132.

Pediatric Oncology

A comprehensive, compact, 3-day course in pediatric oncology, will be available in New York April 25, 26, 27. Held at the Sloan Kettering Institute, this seminar will review the diagnosis and management of neoplastic disease in children. A distinguished faculty has been assembled, and many cases from local hospitals will be presented. The tuition fee is $35. The hours are 8:30 a.m. to 4 p.m. For further details write to: "Pediatric Service, Memorial Center, 444 East 68 Street, New York, N. Y."

Annual Schering Award Competition

The Schering Award has begun its eleventh annual program for medical students in the United States and Canada.

Students participate by selecting one of three subjects and submitting papers to the Schering Award Committee, Bloomfield, N. J. Both a $500 prize and $250 second prize are offered for *each* of the three subjects. Decisions are made by judges who are authorities in their fields. Every participant in the contest receives a professionally useful gift.

The three subjects for 1956 are:

1. Clinical use of adrenocortical steroids in collagen diseases
2. Metabolic aspects of aging
3. New applications of antihistamines in medicine and surgery

Literature and entry forms are being distributed in the medical schools. Students should submit entry forms before July 1, 1956. Manuscripts must be postmarked not later than Sept 30, 1956.

During the past several years, Schering Award-winning papers have been met with increasing interest by professional journals Many have already been published.

Thrombo-Angiitis Obliterans

Professor Walter Redisch will lead a discussion on thrombo-angiitis obliterans at St. Michael's Hospital (306 High Street) in Newark on Thursday, April 19 at 11 a.m. Dr. Redisch is Associate Professor of Medicine at Bellevue. All physicians are welcome to attend.

Steroid Disease

On Tuesday, April 3, there will be a conference on steroid disease at St. Michael's Hospital, 306 High Street, Newark. Discussion will be launched by Dr. Herbert Kuperman, Adjunct Professor of Therapeutics at Bellevue. All doctors are welcome.

Rheumatoid Arthritis

Thursday, April 5 is the date and N. J. Orthopedic Hospital the place for the long-awaited colloquium on the management of rheumatoid arthritis. Scheduled for 9 p.m., the seminar will be opened by Dr. Richard Smith, Directing Rheumatologist at the Benjamin Franklin Clinic in Philadelphia. The meeting will be at 179 Lincoln Avenue, Orange, and you are invited.

Philadelphia Graduate Institute

The ever-popular Graduate Institute of the Philadelphia County Medical Society is announced for April 10 through 13 at the Bellevue-Stratford Hotel in Philadelphia. The seminar covers newest advances in psychosomatics, nutrition, surgery, heart disease, gynecology, diabetes, hypertension, pharmacology, hematology and patient-relations. For details write to Director, County Medical Society, 301 South 21 Street, Philadelphia 3, Penna.

Obituaries • • •

DR. PHILIP S. BORKOW

A freak accident took the life of Dr. Philip S. Borkow on January 8, 1956, when a loose wooden plank from a bridge went through the windshield of his car and struck the doctor in the chest.

Born in Brooklyn in 1913, Dr. Borkow was graduated from the medical school of Dalhousie University in Nova Scotia and interned at Coney Island Hospital in Brooklyn. After five years in the Air Force he came to Morris County and set up private practice in Dover. He was active in the public educational program of the American Cancer Society and was the school physician and police surgeon of Randolph Township in Morris County.

DR. SAMUEL EDELSON

A frequent contributor to this JOURNAL, Dr. Samuel Edelson suffered a fatal heart attack on January 21, 1956. Born in Neptune in 1901, Dr. Edelson was graduated from Hahnemann in 1926. After interning at the Jersey City Medical Center, he returned to his native Monmouth County where he practiced since 1927. He was Neptune school physician, and had been for a quarter of a century. Dr. Edelson served in both wars—as an enlisted man in 1918, as a medical officer in 1943. He was an attending physician at both Monmouth Memorial and Fitkin; and in recent years had limited his practice to internal medicine, with special emphasis on cardiology.

DR. JOSEPH C. FROELICH

Andrew Johnson—Lincoln's vice-president — was President of the United States when Joseph Froelich was born in Newark in 1869. After being graduated from the New Jersey College of Pharmacy, Dr. Froelich decided that medicine rather than pharmacy was to be his career. He was graduated from the University of the South in 1900, and in the following year opened an office for general practice in his native city. There he administered to the medical needs of the community for more than half a century. In 1906 he served as Alderman from the Third Ward. He then became a member, later chairman, of the City Playground Commission. Then he was named as Trustee of the Newark City Home. Through all this, Dr. Froelich managed a busy general practice, being identified with both St. James and Presbyterian Hospitals in Newark. Even at the age of 75 he continued to be active in civic affairs, serving at the time a term on Essex County Mosquito Commission. In his earlier years, Dr. Froelich was active in committee work with the Essex County Medical Society. Dr. Froelich died on January 10, 1956.

DR. JACOB L. FLAX

While on vaction at Miami, Dr. Jacob Flax died on January 23, 1956. Born in Newark in 1899, Dr. Flax was graduated from the Jefferson Medical College in 1923. He interned at the Beth Israel Hospital, and developed an early interest in and skill in surgery. He held surgical appointments at several Newark hospitals, and was Associate Attending Surgeon at Beth Israel at the time of his death. During World War II, Dr. Flax applied for, and received a commission in the Navy and was a commander in the south Pacific theatre for two years.

DR. D. LEO HAGGERTY

One of Trenton's leading surgeons, Dr. D. Leo Haggerty died on October 8, 1955. Born in Pennsylvania in 1893, he was graduated from the medical school of Georgetown University in 1915. He spent the next two years on the house staff of St. Francis Hospital in Trenton, then accepted a commission in the Army. After completion of this service in World War I, Dr. Haggerty returned to his adopted city and joined the staff of St. Francis Hospital as a surgical assistant. Rising through the ranks he became chief of surgery in 1946 and medical director of the hospital in 1948. He was also surgeon to the State Police.

Active in the Mercer County Medical Society, he became president of that body in 1944. Later he was president of the State Society of Surgeons. He was Mercer County's member of the State Nominating Committee at all Annual Meetings between 1942 and 1955. Dr. Haggerty was also active in civic affairs—particularly in the Trenton Symphony Orchestra, The Trent House Association, the American Legion and the Knights of Columbus.

DR. EDWIN FOY UZZELL

A past president of the Atlantic County Medical Society and senior gynecologist at the Atlantic City Hospital, Dr. Edwin F. Uzzell died on January 21, 1956. Born in North Carolina in 1892, Dr. Uzzell was graduated in 1916 from the Jefferson Medical College. He interned at the Atlantic City Hospital here, and then entered the army as a medical officer in World War I. After two years of service, most of it in France, he returned to civilian life and adopted New Jersey as his new home state. He was active in church and and civic affairs. Dr. Uzzell was a well known philatelist and won many awards at stamp exhibits. He engaged in general practice, with increasing interest in surgery and became a Fellow of the American College of Surgeons. He was affiliated with the Atlantic City Hospital all his professional life, eventually becoming chief of the gynecologic service there.

County Society Reports • • •

Atlantic

The regular meeting of the *Medical Society of Atlantic County* was held at the Children's Seashore House on December 9, 1955. The President, Dr. Peter H. Marvel, presided.

Dr. Lucien A. Gregg, Professor of Medicine at the University of Pittsburgh, School of Medicine, spoke about "Abdominal Pain of Obscure Origin." The paper was discussed by Drs. Gleason, Johnson, McCracken, Read and Shavelson.

Dr. Harley recommended the elevation of Dr. Victor A. Bressler and Dr. Joseph Linsk from associate to regular membership. The Committee also approved the application for regular membership of Dr. Bertha Cameron-Guild. The Society voted unanimously for approval of these memberships.

Dr. Timberlake gave a report on a meeting held in New York City on October 29. Dr. Allman commented on Assembly Bill No. 230.

Dr. Sterling Brown offered the following resolution:

1. The members of the Medical Society of Atlantic County, in compliance with state policy and time-honored tradition, express their willingness to provide, whenever indicated, at reduced cost or at no cost, the medical services involved in immunizing the children of this county against preventable diseases, which now includes poliomyelitis.
2. Parents who can readily pay for vaccine and associated medical services can arrange for the injection in the office of their private physician. If the physician believes it necessary he may modify his own fee and he can further assist parents by obtaining the vaccine without cost at one of the State Department of Health Distribution Stations.
3. We believe the interests of public health can best be served in poliomyelitis control by utilizing already established health control facilities rather than by the establishment of a mass immunization program.

Dr. John Holland reported the total cost of the Seventy-Fifth Anniversary Celebration was $2,750. He stated that $1,638 was collected, leaving a net loss of $1,112. It was agreed that the 310 persons attending the Celebration were well pleased with the occasion, and the Society as a whole was satisfied with the nominal cost of such publicity and social activity.

Dr. Gleason stated that Blue Cross premiums were being mailed and checks should be returned to his office immediately. Dr. Gleason told the members that the extended disability policy was highly recommended by the State and also by his Insurance Committee. He also reported a letter had been sent to each doctor in the Society concerning changes in the Medical-Surgical Plan as of January 1, 1956.

Dr. Molitch reported the Welfare Committee was active in helping to develop the Alms House as an institution for the chronically ill. The Committee was also active in improving treatment at the Northfield asylum.

Dr. Green reported that his Liaison Committee is following the adage "What is good for Atlantic City is good for the doctors." The Committee is trying to increase the number of conventions being brought to the city. A definite program is being formed by the Committee to obtain these conventions, and to have closer cooperation between the local society and the various conventions.

LEONARD B. ERBER, M.D.
Reporter

Cumberland

The February meeting of the *Cumberland County Medical Society* was held at the New Jersey State Hospital at Ancora, on February 14. Dr. Nicholas E. Marchione presided during the short business meeting.

Dr. Leonard G. Scott gave an excellent report of the work done by the diabetes committee during the November drive. Our county returned 2938 Dreypaks of the number distributed.

Dr. Albert B. Kump reported on pending legislation and encouraged the members to write individual letters to their congressman voicing their opinion of Bill No. HR 7225.

The members were reminded by Dr. Pasquale A. Ruggieri of the services available through the Cumberland County Heart Association and a report made of recent progress in the organization.

Dr. Marvin N. Solomon was unanimously elected to active membership, and Dr. Francis N. Campagna, a new associate member, was introduced to the group.

Dr. Mary Bacon reported on the meeting of the nominating committee, and announced with regret the passing on February 12 of Dr. Margaret Warlow, an honorary member of the Cumberland County Medical Society.

Following adjournment of the business meeting there was a conducted tour of the hospital demonstrating the operating rooms, x-ray, physiotherapy, electro-encephalograph and other excellent facilities.

After a discussion of commitment procedures by Dr. Michael Mendelson of the State Hospital staff, a fine dinner was served to the twenty-seven members in attendance.

PAUL K. AYARS, M.D.
Reporter

Hudson

With Dr. Sigmund C. Braunstein presiding, *Hudson County Medical Society* held a meeting on January 3 at Jersey City Medical Center.

At the December 6, 1955 meeting, the secretary was directed to write the A.M.A. for its opinion on the full-page advertisement of Spears Chiropractic Hospital in Denver which appeared during the month of November in the *Jersey Journal* and the *Hudson Dispatch*. At this meeting (January 3) Dr. Braunstein read the reply of Mr. Oliver Field, Director of the A.M.A. Bureau of Investigation, which contained the following information:

> The A.M.A. has record of Leo Spears in its quackery files for the past thirty years.
>
> In October 1955, Mr. Spears sued the Denver Post and Denver Area Better Business Bureau for $11,000,000 for having conspired to ruin his business. After three weeks' trial, the court concluded that not only had Mr. Spears failed to prove his charge, but that it had been shown that the Spears Free Clinic and Hospital for Poor Children was being operated illegally.
>
> In May 1951, Spears brought a $24,000,000 libel suit against *Colliers'* for having mentioned him in an article entitled "Cancer Quacks." The jury found the publisher not guilty, the attorneys having proved that what had been said about Spears was true—that he was a cancer quack.
>
> In still another lawsuit, physical examination of Mr. Spears revealed him to be a diabetic and to be on insulin, although diabetes is included in the "Partial List of Ailments Being Effectively Treated at Spears."

The A.M.A. letter was sent to the Editor of both the *Jersey Journal* and the *Hudson Dispatch*.

Elected to membership at this meeting were Dr. Charles L. Brown, Dr. Louise Fialkowski, and Dr. Vladimir Onuferko—all of Jersey City; and Dr. Charles Kuntze of Fort Lee, who is practicing in Hoboken.

Dr. John S. Reitnauer was transferred from the Bergen County to the Hudson County Medical Society.

The scientific session consisted of a discussion of "Viral Hepatitis" by Dr. George W. Melcher, Associate in Medicine at Columbia University College of Physicians and Surgeons.

Hudson County Medical Society convened in regular monthly session, under the chairmanship of Dr S. C. Braunstein, on February 7 at Jersey City Medical Center. Elected to active membership were Dr. Albert Ehrlich of Palisades Park and Dr. Gregory Jawny of Jersey City.

Referred to the Executive Committee was a communication from the Jersey City Chapter of The American Red Cross—which emphasized the current acute need of expanding the sources of blood supply in this area and suggested the possibility of Jersey City's becoming a participant in the New York Regional Blood Program.

During the scientific session, the acute abdomen was discussed by Dr. Samuel Standard, Associate Professor of Surgery, N. Y. U. College of Medicine, Drs. Frank Bortone, Louis Perkel, Robert Rubenstein, and Edward G. Waters participated in a discussion from the floor.

CHARLES A. LANDSHOF, M.D.

Reporter

Middlesex

The regular monthly meeting of the *Middlesex County Medical Society* at Roosevelt Hospital, Metuchen, January 18, 1956, was called to order by the President, Dr. Joseph F. Sandella.

Dr. Norman Rosenberg, County Medical Coordinator for Civil Defense and Disaster Control, introduced a panel of authorities who discussed the treatment of mass casualties as related to civilians.

Mr. L. W. Livingston, County Coordinator for Civil Defense and Disaster Control, outlined the handling of mass casualties. He was followed by Mr. Anthony Eckert, Director of Perth Amboy General Hospital, who spoke from experience of the role of the hospital in disaster control. He discussed the mismanagement of mass casualties with its resultant confusion, and what could be done to rectify the situation.

Dr. John Henderson, Medical Director of Johnson and Johnson then presented a gruesome picture of the total number of casualties to be expected and the problems of first aid. The onus of survival eventually falls on the man in the street, and his knowledge of first aid. This information properly applied may spell the difference between disaster and survival.

Dr. B. F. Slobodien, Chairman of the Judicial Medical Ethics Committee presented for approval, applications for associate membership from Dr. Edward Sherwood of New Brunswick, sponsored by Drs. J. S. Winn and J. J. Kangos; Dr. Charlotte Weiss of New Brunswick, sponsored by Drs. Howard E. and Lydia Adler. Both applications were approved.

Mrs. Ivan B. Smith, Mrs. Rubin and Mrs. N. Gorog of the Woman's Auxiliary presented a "Pageant of the History of Nursing." This well done presentation has been shown to some 10,000 students in the schools of our county. It portrays the role of nurse and their garb from the birth of modern nursing to the present day. Primarily it has been a nurse recruitment instrument. It is also an excellent history of nursing.

Dr. Gessner reported on the poliomyelitis vaccination program as follows: (1) Through federal and state funds only 27 per cent of the vaccine is available for free inoculation to age groups one to fifteen and pregnant women. (2) Physicians who are municipal employees may carry on whatever program has been outlined by the municipality, even though it is not in conformity with the proposal of the Board of Trustees of The Medical Society of New Jersey.

The Committee urged the employment of a press

relations representative and this was approved by an overwhelming vote.

Return of a questionnaire regarding the utilization of poliomyelitis vaccine indicated about an equal number of injections in private offices and in schools. Some 10,000 injections were given in each category.

Dr. Gurshman read a communication from the Medical-Surgical Plan of New Jersey, explaining their attitude in third party participation, especially as it applies to public liability cases. In brief the participating physician who accepts payment from the Medical-Surgical Plan is considered paid in full and cannot submit an additional bill to the subscriber for payment of the same medical or surgical care.

The meeting was adjourned at 11:45 p.m. and collation followed.

ALFRED J. BARBANO, M.D.
Reporter

Monmouth

The regular monthly meeting of the *Monmouth County Medical Society* was held at Monmouth Memorial Hospital, Long Branch, on January 25, with Dr. William F. Jamison, the President, presiding.

The scientific session featured two prominent speakers. Dr. Harry Gold, Professor of Pharmacology at Cornell, spoke on "The Treatment of Coronary Artery Disease." Dr. Charles Bailey, Professor of Thoracic Surgery at Hahnemann Medical College discussed "Surgery of the Coronary Arteries."

The Society passed a resolution honoring the memory of the late Dr. Samuel Edelson and recorded its grief in the loss of a truly great physician and humanitarian. A contribution was made in the name of the Society to the Samuel Edelson Memorial Fund.

Elected to active membership were the following: Drs. R. Dean Coddington, Red Bank; Helmut Cohen and Charles C. Graves, New Jersey State Hospital, Marlboro. Dr. Koon T. Ma, Fair Haven, was elected to associate membership.

The Annual Winter Dinner-Dance conducted jointly by the Society and its Auxiliary was held at the Berkeley-Carteret Hotel on February 4. Dr. and Mrs. Paul Bornstein were co-chairmen of the affair which set an all-time record in attendance.

DONALD W. BOWNE, M.D.
Reporter

Morris

The regular January meeting of the *Morris County Medical Society* took place at Spring Brook Country Club on Thursday evening, January 12, at 6:00 p.m. In the absence of Dr. Harold Hatch, Vice-President George Nicoll presided.

Guests for the evening were the officers and members of the Morris County Bankers Association. Numerous special guests attended from various parts of the state including Dr. Vincent P. Butler, President of The Medical Society of New Jersey.

The meeting was primarily social and refreshments were enjoyed by all. A short business meeting took place and Dr. F. Clyde Bowers presented a series of revisions to the consitution and by-laws of the Morris County Medical Society.

Dr. Butler addressed the members and the guests extemporaneously on common interests in communal affairs and his talk was enthusiastically received.

ALBERT ABRAHAM, M.D.
Reporter

Passaic

The regular meeting of the *Passaic County Medical Society* was held on Tuesday, January 17 at the Medical Society Building. Dr. Joseph R. Jehl, the President, presided.

The following were elected to active membership: John C. Frommelt of Pompton Lakes and Dr. Aaron W. Rosendale of Prospect Park.

Dr. Jehl brought to the members' attention an announcement from E. & W. Blanksteen, stating that the National Casualty Company had allowed a 30 days extension for enrollment of the new Extended Professional Disability Policy. Twenty-three more applications from this county were needed to qualify our group.

Dr. Jehl read excerpts from reports of The Medical Society of New Jersey and the American Medical Association concerning H. R. 7225, urging the members to oppose this bill.

The President spoke about the financial problem of the Homemakers Service and asked Dr. Warburton, Chairman of the Woman's Auxiliary Committee, to present this situation more fully. He explained the reason for the overhead of this Service being greater than the income. After considerable discussion and further explanation, the treasurer was authorized to donate $250 to the Homemakers Service to aid them in their endeavors.

The President then turned the meeting over to Dr. Gerhard R. Hirschfeld who introduced the speaker, Nathan S. Kline, M.D., Director of Research, Rockland State Hospital, Orangeburg, N. Y. Dr. Kline's topic was "Reserpine and Chlorpromazine in Medical Practice."

Following the question period, refreshments were served.

DAVID B. LEVINE, M.D.
Reporter

Salem

At the January meeting, with Vice-President Lipkin in the chair, the *Salem County Medical Society* heard a report from its executive committee. The report (which follows) was approved as the sense of the Society and the secretary was authorized to release it to the newspapers of Salem County in the form of advertisements. Here is the report:

1. The Society believes that every child should be immunized against poliomyelitis with the Salk Vaccine.
2. The Society further believes that wherever possible the vaccine should be obtained from the family physician on a fee-for-service basis. This insures a careful check of the child when necessary plus a recording of the injection on the child's history. Further, the proper timing of the injections for maximum protection can also be best determined and prescribed by the family doctor.
3. The Society primarily sponsors and has sponsored for three months a program for those persons unable to meet the usual charge of the doctor for the Salk Vaccine. These persons apply to the local school nurse for a slip authorizing use of the state-supplied vaccine; no charge will be made when this slip is presented to the family physician. This program insures that no one shall go without the vaccine for want of means to pay.
4. The Society does not basically approve of the distribution of the vaccine through free municipal clinics. However, since certain amounts of the vaccine are now available through such clinics and it would be undesirable to let this vaccine leave the county, the members of the Society will administer the injection of the vaccine. This vaccine is adequate in amount to immunize only a relatively small proportion of eligible children. The Society feels that this vaccine should be sought only by those persons who feel they cannot afford the usual physician's charge. No "means test" can be applied at these clinics and hence the proper allocation of this vaccine will depend only upon the individual consciences of the parents concerned.

Dr. Eugene Pashuk read a letter from Dr. Blaisdell, urging members to oppose bill H. R. 7225. This is a federal social security bill regarding cash payments for disability. Dr. Boyer moved that we send a telegram from the Society to our U. S. Senators asking that action on this bill be deferred until it has been studied and discussed more thoroughly.

CHARLES E. GILPATRICK, M.D.
Reporter

Somerset

Dr. John L. Spaldo, President, presided at the regular monthly meeting of the *Somerset County Medical Society* held on January 12, at the Somerset Hospital.

The following resolution was passed by the Society:

Whereas, it is evident that payments for certain medical services are now incorporated in Blue Cross Hospitalization Plan contracts for direct payment to the subscribing hospitals, and,

Whereas, this concept is foreign not only to *our* ethical principles but also to those of the American Medical Association, Therefore:

Be It Resolved, that the Somerset County Medical Society go on record as recommending the deletion of such payments for medical services from New Jersey's Blue Cross Hospitalization Plan and any other statements in the Blue Cross contract implying coverage of medical services; and that such services be included in the Blue-Shield Medical-Surgical Plan of New Jersey, and

Be It Further Resolved, that a copy of this resolution be sent to The Medical Society of New Jersey for appropriate action.

Dr. Hyer reported that the Johns-Manville recreation grounds are available on June 17 for the Annual Clambake.

Dr. John Preece, Chairman of the Maternal Welfare Committee of the state medical society gave an interesting presentation with slides.

MARCUS E. SANFORD, M.D.
Reporter

New Jersey Orthopaedic Society

At its first meeting of the 1956 season, Dr. William Kruger of Newark was elected President of the *New Jersey Orthopaedic Society*. Dr. Harold T. Hansen of South Orange became Treasurer, Dr. Arthur S. Thurm of Trenton, Secretary. Dr. Bernard M. Halbstein of Long Branch was named President-Elect.

ARTHUR S. THURM, M.D.
Reporter

Auxiliary Report • • •

Essex

Mrs. Ralph R. Autorino, President, chaired the regular monthly meeting of the *Essex Auxiliary* held on January 30 at Graulich's, 369 Park Avenue, Orange. After the business meeting Mrs. Robert J. Citrino, Chairman of the Arts and Hobbies Committee announced plans for a variety show and art exhibition in order to show off the talents and hobbies of Auxiliary members. The show presented was entitled, "An Armchair World Cruise." As Mrs. Frank M. Galioto narrated, the S. S. Auxiliary Cruise visited such places as Ireland, the Mediterranean, Venice, Germany, Vienna, Arabia, Hawaii, Bali, and returned to New York City. At various ports, members of the Auxiliary sang and danced in colorful native costume to music representative of the places visited. Soloists included Mrs. Arthur Ruccia, Mrs. C. Joseph Ferri, and Mrs. Harold Grubin. Solo dances were done by Mrs. Frank D. Bellucci and Mrs. Joseph Di Norcia. Two-piano selections were played by Mrs. Isabelle De Marco Nemzek. Other members of the cast included Mrs. Leon P. Nutzel, Mrs. Thomas Cantalupo, Mrs. John Insabella, Mrs. Thomas A. Messina, Mrs. Anthony Giannotto, Mrs. Matthew J. Marano, Mrs. Louis L. Covino and Mrs. Anthony Biunno.

After the musical show, tea was served. Both members and guests then visited the collection of paintings hung in the two front parlors. Mrs. Paul Aszody, chairman, and Mrs. Ames Fillippone, co-chairman, were in charge of the exhibition and also showed paintings. Other members exhibiting were Mrs. John J. McGuire, Mrs. Michael Pierce, Mrs. Arthur Ruccia, Mrs. Gene D'Allessandro, Mrs. Alfred D'Agostino and Mrs. Charles J. Calasibetta.

Other members who assisted in planning the meeting were Mrs. Edwin H. Albano, Mrs. Edward P. Duffy, Jr., and Mrs. Alvin Mancusi-Ungaro.

MRS. CHARLES J. CALASIBETTA,
Chairman, Press and Publicity

MRS. EDWIN H. ALBANO, Co-chairman

Book Reviews • • •

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

Hiroshima Diary: The Journal of a Japanese Physician. By Michihiko Hachiya, M.D. Translated by Warner Wells, M.D. University of North Carolina Press, Chapel Hill 1955. Pp. 238. ($3.50)

The author was the first physician to see victims of the Hiroshima atom bomb. He describes the unfolding of their medical symptoms with emphasis on the brutalizing effect of this weapon on the daily lives of humble people. There is the unspoken implication that we Americans are pretty nasty characters for having unleashed this bomb. At no point is there the slightest suggestion that Dr. Hachiya sees any guilt in the activities of his own people. There is no criticism for the policy which sent peace missionaries to Washington while it rained death on civilians at Pearl Harbor. There are no regrets for the victims of Japanese death marches or for conditions in Japanese P.O.W. camps but only an orgy of self-pity for those who were killed or sickened by the world's first atom bomb.

HENRY A. DAVIDSON, M.D.

Surgical Forum. Proceedings of the Fortieth Congress of the American College of Surgeons. Pp. 851. Philadelphia, Saunders Company (1955). ($10.00)

The 1954 edition of "Surgical Forum" is the most recent volume in what is proving to be a valuable collection of books reflecting the current and future thinking of progressive American surgery. Most of these papers demonstrate the growing interest of young surgeons in the essential basic sciences of biochemistry, physiology and bio-physics as stepping stones into the more complex surgical explorations and modifications of the human anatomy.

Much of the experimental animal cardiac and vascular surgery heralded in previous "Forums" is now reported as clinically applicable with reasonable mortalities. For those interested in cardiac surgery, the excellent studies on functional valvular and reconstructive intracardiac surgery is of particular interest along with the work on safe methods for open surgery within the cardiac chambers. From these reports one can well imagine the day in the

near future when exploration of the heart will be as common-place as exploration of the thorax or cranium.

Esophagitis, surgical physiology of the stomach and the altered physiology of the total gastrectomy problem occupy most of the interest of this section of the volume.

The section on the relation of steroids and cancer sheds some new light on this most important phase of the cancer problem.

The contributions of anesthesiology to modern surgery are given their due recognition. Papers on burn, shock and wounds maintain the general excellence and wealth of new information to be found in this book.

While much of the material to be found in this, as well as in past "Surgical Forums," is of an experimental nature, a complete set of these volumes would reflect the rapidly expanding horizons of American surgery and is highly recommended reading for all surgeons.

ARTHUR J. D'ALESSANDRO, M.D.

Nursing Practice and the Law. M. J. Lesnik and Bernice E. Anderson. Lippincott, Philadelphia 1955. Ed. 2. Pp. 400.

If you are working indirectly or directly with patients you will find *Nursing Practice and the Law* a valuable and informative volume. It includes information of pertinence to every nurse, professional and practical, and is of no less value to allied disciplines.

The first edition (published in 1947) I used during a course called legal aspects of nursing. Since that time I've found this great contribution a realistic, practical and applicable source of reference to own and use extensively. In well-organized fashions, the book covers: The meaning of law and its relationship to nursing, legal procedure, trial, the legal control of nursing, analysis and evaluation of nursing practice acts, contracts for nursing service, the legal status of nurses, implications of liability for torts, negligence, malpractice, crime and wills. A summary of the Social Security Act and benefits available also may be helpful to many. Illustrations of cases from actual situations involving patients, nurses, doctors and the law are clearly and concisely presented with technical language at a minimum. Its value is enhanced by the extensive bibliography.

The importance of defined nursing functions and standards is emphasized. As these functions and standards change in the light of newer findings and concepts the role of the nurse also changes. Since a nurse is held legally responsible for the care of her patients, even though she may share this responsibility with the agency which employs her, it is essential for her to be aware of and to consider carefully her legal responsibilities. This text is an excellent and practical way of acquainting the nurse with the law as it affects her and her practice.

I conclude with this quotation from the book, "If rules of conduct have been, are or may be declared which define, prescribe, limit or affect the activity of nursing then it would appear incumbent upon one engaged in that profession to know what those basic rules of conduct are."

ELISABETH VISZOKI, R.N., M.A.

Community Programs for Mental Health. Edited by Ruth Kotinsky and Helen Witmer. Cambridge, Mass., Harvard University Press, 1955. The Commonwealth Fund. Pp. 362. ($5.00)

Eight authors, only two of whom are physicians, have written articles which, when strung together, make up this book. The dust wrapper says that the purpose of this volume is to "provide an overall view of mental health promotion." Accordingly, one will want to look in the index for such headings as "staffing" or "financing" or "appraisal." One looks in vain. There is no index.

The core of the book is a pair of chapters—one by Barbara Biber, Ph.D. and one by H. E. Chamberlain, M.D. together with Elizabeth De Schweinitz, MSW. These chapters deal with the public schools as mental health agencies and with certain particular on-going community mental hygiene programs. The book is heavy with social work jargon which makes it a little hard to read. Examples: "concept-oriented social studies," "personalities loom large in giving programs their shape and form" (are you surprised at this keen observation?), "maturing is learning to accept things as they are," "workshops" "frames of reference" "indices for assessing community integration" "focus attention upon the total structure," "conceptual framework," "methods need new thinking, experimentation and clarification" and "responsive resilience in staff relationships."

If you are willing to cut through the layers of mumbo-jumbo you will find here some solid stuff about developing and promoting community mental health programs.

HERBERT BOEHM, M.D.

The Relief of Symptoms. By Walter Modell, M.D. Philadelphia 1955. W. B. Saunders Company. Pp. 450. ($8.00)

A curious and almost snobbish attitude seems to have developed about meliorative medicine. You have to apologize if you want to bring solace to your patient by relieving symptoms, unless you can also strike a blow towards cure of the underlying disease. There are, admittedly, certain hazards in seeking symptomatic relief as the immediate goal of therapy. But Dr. Modell believes—and with reason—that our defensiveness about this has gone too far. So he has written a book which frankly seeks to teach nothing more than symptomatic

relief. He lists the 24 symptoms which, he says, account for 95 per cent of all visits to doctors. These are: pain, anxiety, insomnia, "gas," diarrhea, obesity, constipation, anorexia, palpitations, edema, dyspnea, cough, fever, fatigue, vertigo, itch, hiccups, unconsciousness, convulsions, spasms, menstrual disorders, dysuria, jaundice, nausea and vomiting. For each symptom he lists possible causes and then spells out an exact treatment program including indications, dosages, contra-indications and methods of administration. A unique book, and one which will probably be consulted frequently by the general practitioner.

HARVEY BLUESTONE, M.D.

Control of Communicable Diseases in Man. Official Report of the American Public Health Association. Ed. 8. Paper. Pp. 219. American Public Health Association, New York 19, N. Y., 1955. (65c.)

This manual has passed through enough editions to insure its reliability and usefulness. From the first booklet prepared by Dr. Haven Emerson in 1917, it has expanded to include descriptions of 118 specific diseases. Through the World Health Organization it is also available now in 10 different translations.

The contents are arranged in handy alphabetical order. Following the preface and a section defining technical terms, each disease is described according to identification, etiologic agent, source and reservoir of infection, mode of transmission, incubation period, period of communicability, susceptibility and resistance, occurrence and methods of control. Diseases included are due to bacteria, rickettsia and viruses, fungi, spirochetes, protozoa and helminths.

A practical little volume which serves a definite need, this handbook will prove useful to all students and practitioners, nursing and public health workers and others interested in the control of communicable diseases in man.

FRED B. ROGERS, M.D.

Impartial Medical Testimony. A Report from the Association of the Bar of the City of New York. 1956. Macmillan. Pp. 188. ($3.95)

One of the corner-stones of your liberty is your right to summon witnesses to be heard on your behalf. In a personal injury case, it is common for the patient's own physician to testify that there is considerable disability and for the defendant's doctor to pooh pooh the disability. Each doctor is subject to cross examination, and the whole is yardsticked by the common sense of the man in the street.

Under this system a lot of money has been paid to a lot of plaintiffs, and insurance companies don't like it. Insurance companies have one great advantage over the average little plaintiff. The company can employ the best known doctors in town and pay the best fees. An indigent plaintiff obviously can't afford this. However, so long as the patient keeps his right to have witnesses heard on his behalf, he has some protection.

It is now proposed to destroy that right by bringing in an "impartial" physician. The usual practice would be to name as an "impartial" witness, the doctor who would, under ordinary conditions, be a defense expert. Since the jury would be told which was the "impartial" witness, the effect would be to destroy the value of the testimony given by the patient's own doctor. The judge and jury would see the latter as "partisan" whereas the other doctor would be cloaked in the robes of "impartiality."

This book is a report of a two-year project in New York, in which the medical society selected "impartial" experts. The court decisions, say the editors, were often "molded by the testimony of the impartial witnesses." As could be predicted, the net effect was to hurt patients far more than insurance companies. The report here admits that "impartial experts find more often against plaintiff's medical claims than in favor of them." For instance, in 100 consecutive x-rayed cases, the "impartial" radiologist disagreed with the interpretations of the plaintiff's radiologist 24 times. The assumption then was that, of course the plaintiff's radiologists were wrong. Of the 24 "errors," 23 were revised against the patient and one in his favor. The book is chock-full of summaries which show how plaintiff's claims went into tailspins when the "impartial" experts got into the cases. The impartial doctors were instructed to submit a bill for whatever they would have charged an ordinary patient in "moderate circumstances." This turned out to average $55 for each examination!

Lest any doctor try to give full weight to his patient's disability, the editors warn that under this system, "doctors cannot *sell* slanted medical reports without the consciousness that their work may be reviewed by the leaders of the profession." (This is nominated as the most sanctimonious statement of the week). What the defendant's doctor reports is, apparently, being delivered as a public service. When the patient's own physician tells the story, he is "selling" the report.

It is hard to swallow the theory that an eminent doctor will give a more exact prognosis and evaluation than will an obscure or ordinary doctor. And when it comes to revealing error and bias, a vigorous cross examination is still the best lie detector ever invented.

HENRY A. DAVIDSON, M.D.

TUBERCULOSIS *Abstracts*

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A LOOK AT HOME CARE

By Julia M. Jones, M.D., Bulletin, National Tuberculosis Association, *September, 1955.*

The recent increase in home treatment of tuberculosis patients has been much discussed. Some patients have always been treated outside hospitals, either from preference or because of a shortage of beds. Now with more effective treatment methods it is reasonable to broaden home treatment criteria if quality of medical care can be maintained.

Whether or not the idea is good, home care is already widely practiced. What is needed now is a critical evaluation of unhospitalized patients and criteria for the selection of patients and for providing suitable medical care. Experience with chemotherapy is still of short duration and there are many unanswered questions regarding its efficacy. In adapting chemotherapy to home treatment the limitations should be considered.

Streptomycin and isoniazid are highly effective when properly administered. Isoniazid can be given by mouth and parenteral injections of streptomycin can be made by visiting nurses or in clinics. Symptomatic response is prompt, and the volume and infectivity of pulmonary secretions are usually reduced. Present knowledge indicates that, to be effective, treatment must be prolonged for a year or more and must be continuous, that streptomycin and isoniazid are best given in combination or with para-aminosalicylic acid, and that surgical treatment is often necessary.

These drugs are usually not dangerous, but rarely toxic manifestation may require a change in drug regimen. Toxicity usually develops early and complications can be avoided if new cases are hospitalized during the preliminary period. Drug therapy is more often limited by the onset of bacterial resistance to the drugs, which is encouraged when therapy is interrupted or drugs are not given in proper combination. Extra efforts must be made to insure continuance of therapy when patients are treated outside the hospital.

Adequate observation of patients receiving drug therapy requires frequent clinical and roentgenologic observation and detailed laboratory studies. Since drug therapy is usually dramatically effective in relieving symptoms and is apt to encourage false optimism, thorough education of the patient is important at the onset and throughout treatment. It is difficult to achieve the same degree of understanding during brief office and clinic visits that is possible in the hospital.

It must be recognized that there are advanced cases of tuberculosis which cannot be cured and the patient remains a respiratory cripple. Although hospitalization provides only custodial care for these patients, outside the hospital they are potentially dangerous to the community. The patient at home is not necessarily ambulatory, and if needed rest at home is impossible the patient should remain in the hospital. Additional benefits of rest should not be compromised in order to treat the patient at home.

As treatment methods become simpler and more easily administered, it may be anticipated that the specialist will deal only with the more complicated clinical situations. Unfortunately, the past isolation of tuberculosis patients has also isolated clinical experience and knowledge. Medical students, residents and practicing physicians need more experience and instruction regarding tuberculosis.

In the past hospitalization has been urged not

only for the patient's benefit but also to isolate him during the infectious period. Does drug therapy reduce the danger of contagion sufficiently to ignore this safeguard? Factual data are needed before this question can be answered. It seems wise, however, to combine drug therapy with precautionary measures. The patient at home and his familial contacts should be carefully instructed as to hygienic precautions and kept under close observation.

Some enthusiasm for home care is based on the assumption that it is less expensive. For the self-supporting patient, home care may be less costly than prolonged hospitalization, but when treatment is at community expense this saving is less certain. The patient still requires medical and nursing care, must be housed and fed, and his family must be assisted. This cannot be assumed to be inexpensive until overall costs have been studied.

In the hospital the patient can be provided with medical and other necessary services. When patients are geographically dispersed, services become difficult to provide and the treatment team, including doctors, nurses, social workers, vocational counselors, public health nurses and recreation workers may be too dispersed to be efficient. Provision of such services for unhospitalized patients is a challenging problem. Relapse is now less frequent following effective treatment, but relapse potentialities still exist and may be decreased by careful rehabilitation.

Home treatment offers advantages for selected patients if all clinical and personal needs can be met. Family integrity can be maintained with the patient as a participating member. The successful "home treatment" patient must assume greater responsibility for his conduct and treatment, thus avoiding attitudes of dependency. The home should be physically adequate and family relationships must be sound.

Application of home treatment is limited for the numerous detached, homeless men who attend clinics from unsheltered living situations. Many of these patients adapt poorly to institutional life. In general the poorly adjusted individual is a poor patient inside or outside a hospital.

During the period of preliminary hospitalization for new tuberculosis cases long-range plans can be formulated after doctors, social workers, and vocational advisors have evaluated individual needs. When suitable clinical response has been made, the patient can return to a well-planned home situation. Ideally he will then continue under supervision of the same staff. Later surgical therapy may be necessary and this can be performed as part of a well-integrated, continuous program of treatment. If home treatment connot be continued under the auspices of the hospital in which treatment began, detailed information and plans should be transferred to the patient's private or clinic physicians and social workers.

Hospital services are needed for new cases, for the clinically ill, and for specialized services such as thoracic surgery. The asymptomatic patient on prolonged drug therapy and the convalescent patient under continuing clinic supervision can be treated at home if suitable arrangements can be made.

Much is to be gained from sharing experience in a period of change. A pooling of information from various parts of the country where home treatment programs are in progress should contribute to our understanding of the questions which have been posed regarding home treatment of tuberculosis.

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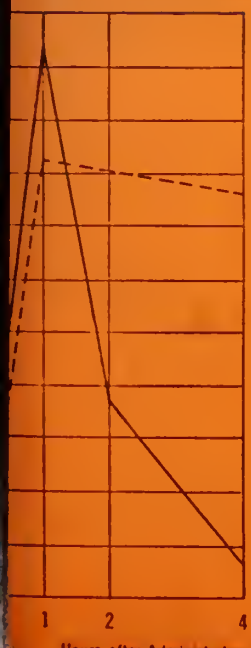
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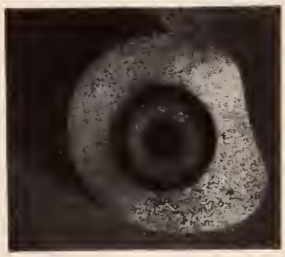
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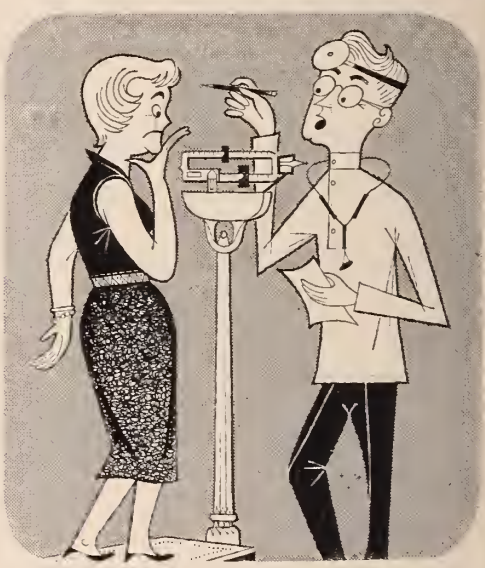
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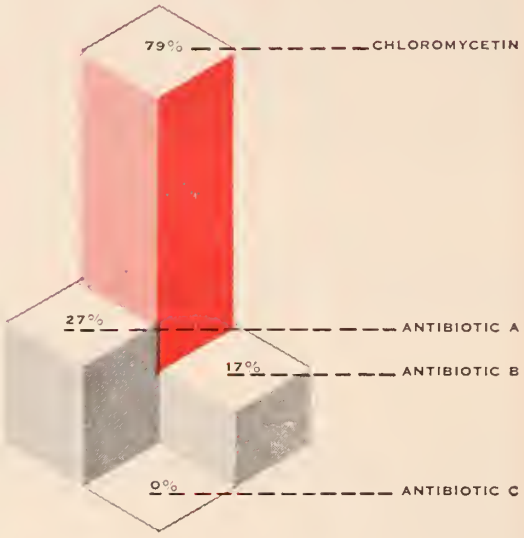
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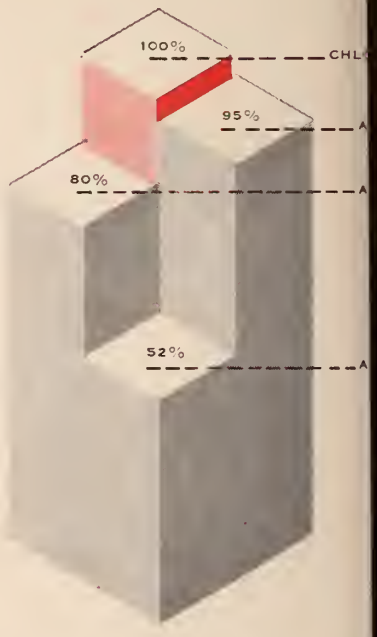
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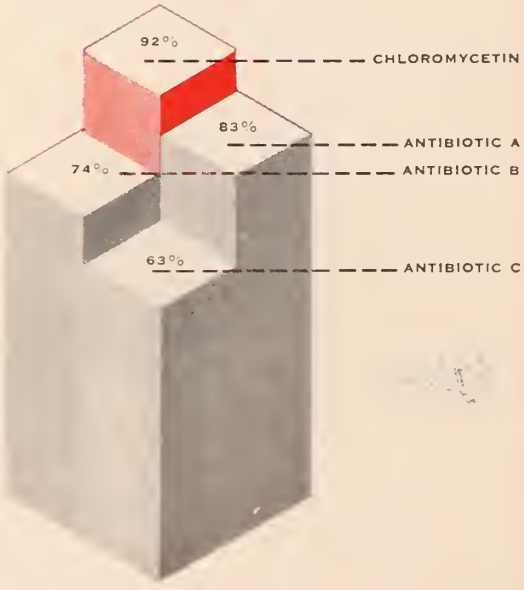
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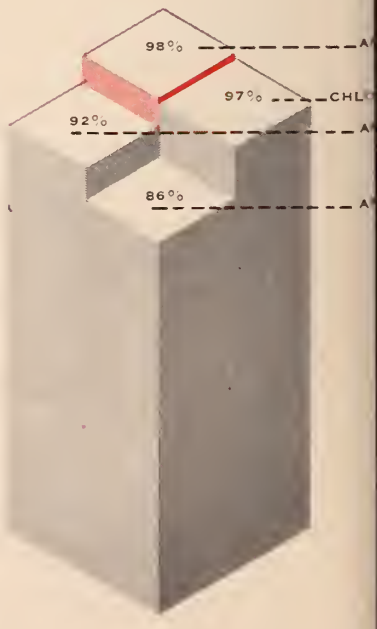
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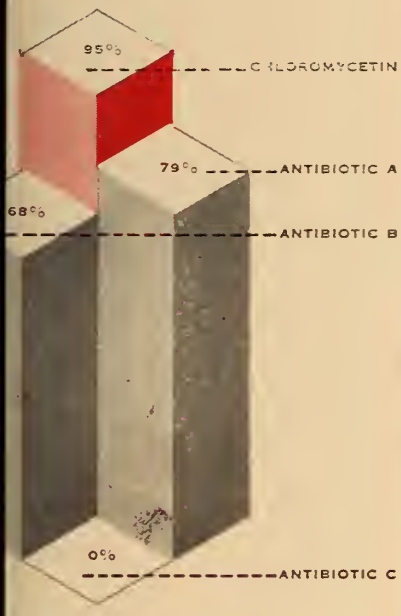
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1. Howell, T.H., et al.: Practitioner *173*:172 (Aug.) 1954.

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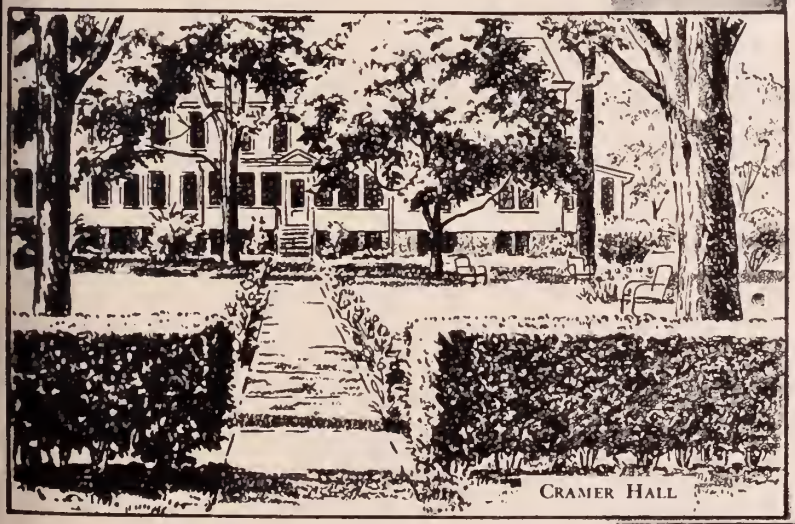
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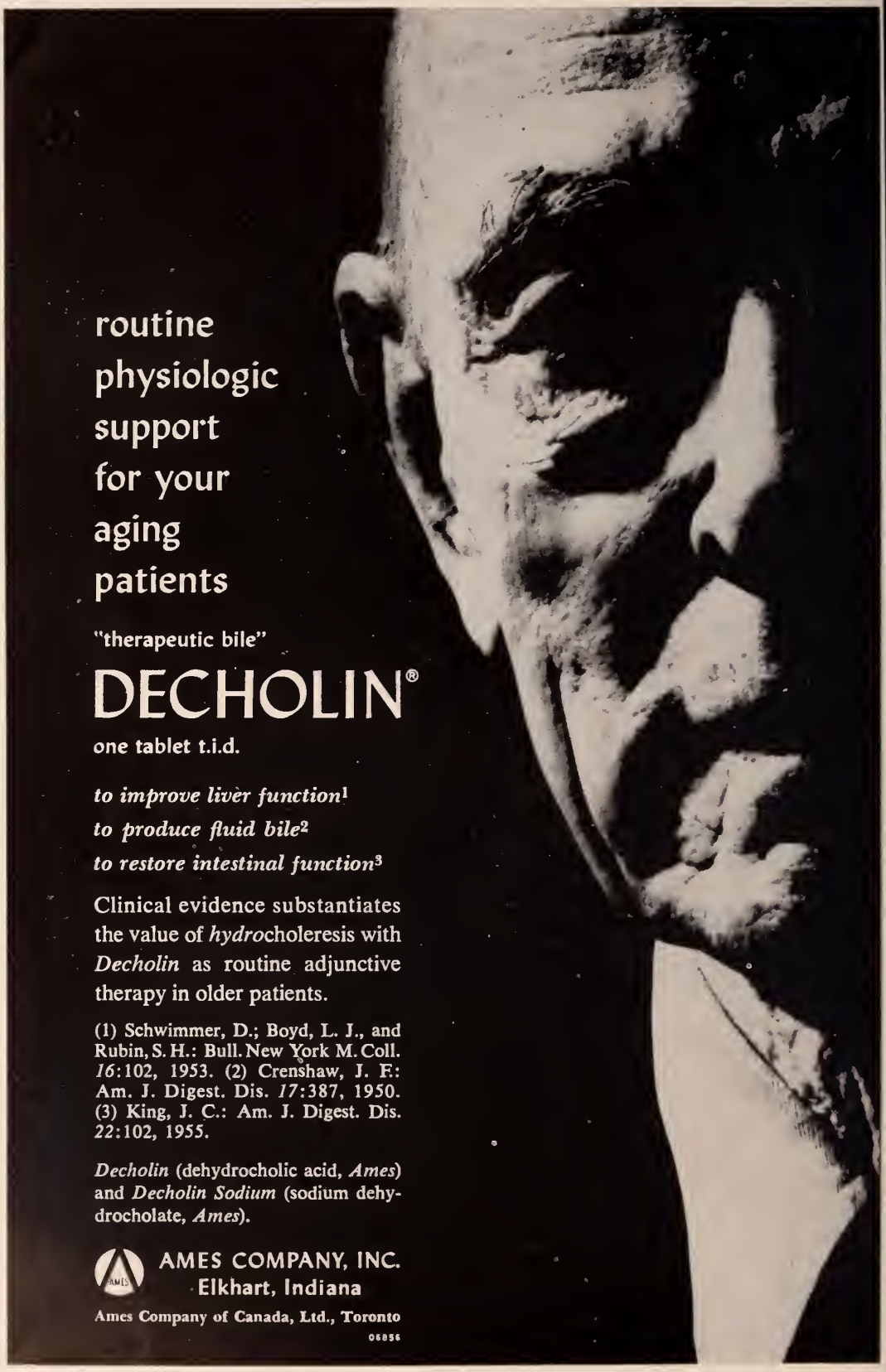
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(1) Schwimmer, D.; Boyd, L. J., and Rubin, S. H.: Bull. New York M. Coll. *16*:102, 1953. (2) Crenshaw, J. F.: Am. J. Digest. Dis. *17*:387, 1950. (3) King, J. C.: Am. J. Digest. Dis. *22*:102, 1955.

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*Clinton, M., Round Table Discussion: New York J. Med. *54*:181, 1954.

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(1) Payne, R. W.; Shetlar, M. R.; Farr, C. H.; Hellbaum, A. A., and Ishmael, W. K.: J. Lab. & Clin. Med. 45:331, 1955. (2) Bunim, J. J.; Williams, R. R., and Black, R. L.: J. Chron. Dis. 1:168, 1955. (3) Holbrook, W. P.: M. Clin. North America 39:405, 1955.

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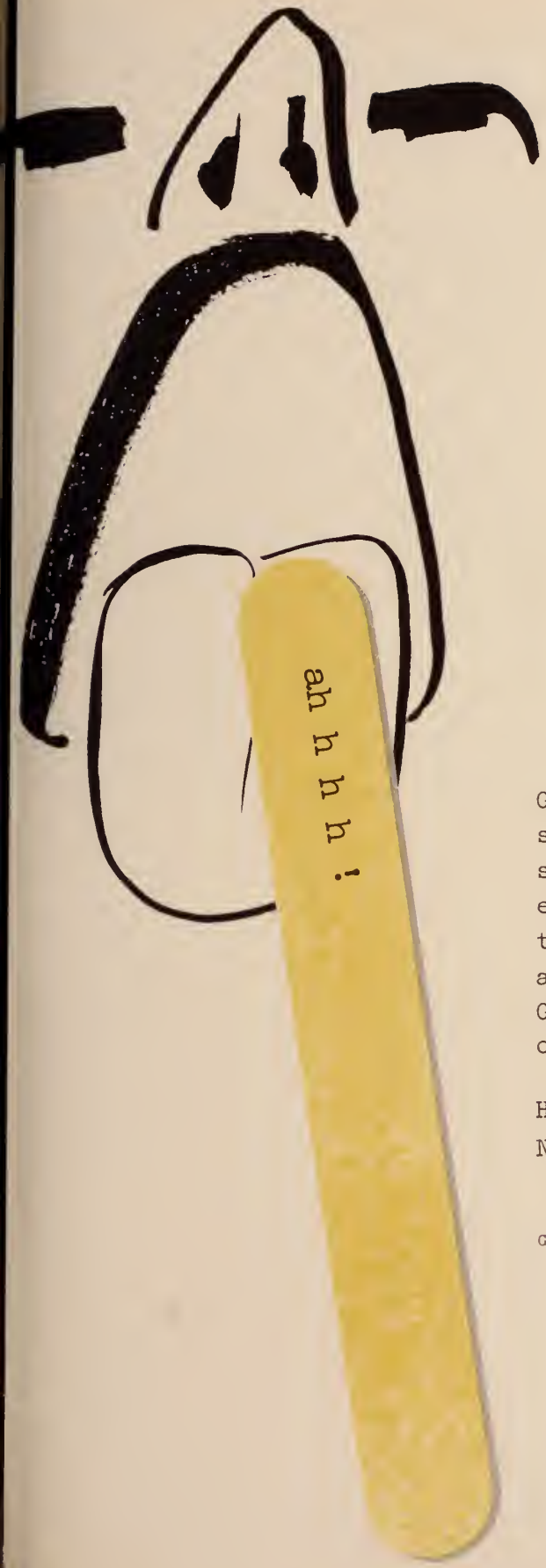
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*Ferrer, F. P., and Boyd, L. J.: Am. J. Dig. Dis., 22:272, 1955



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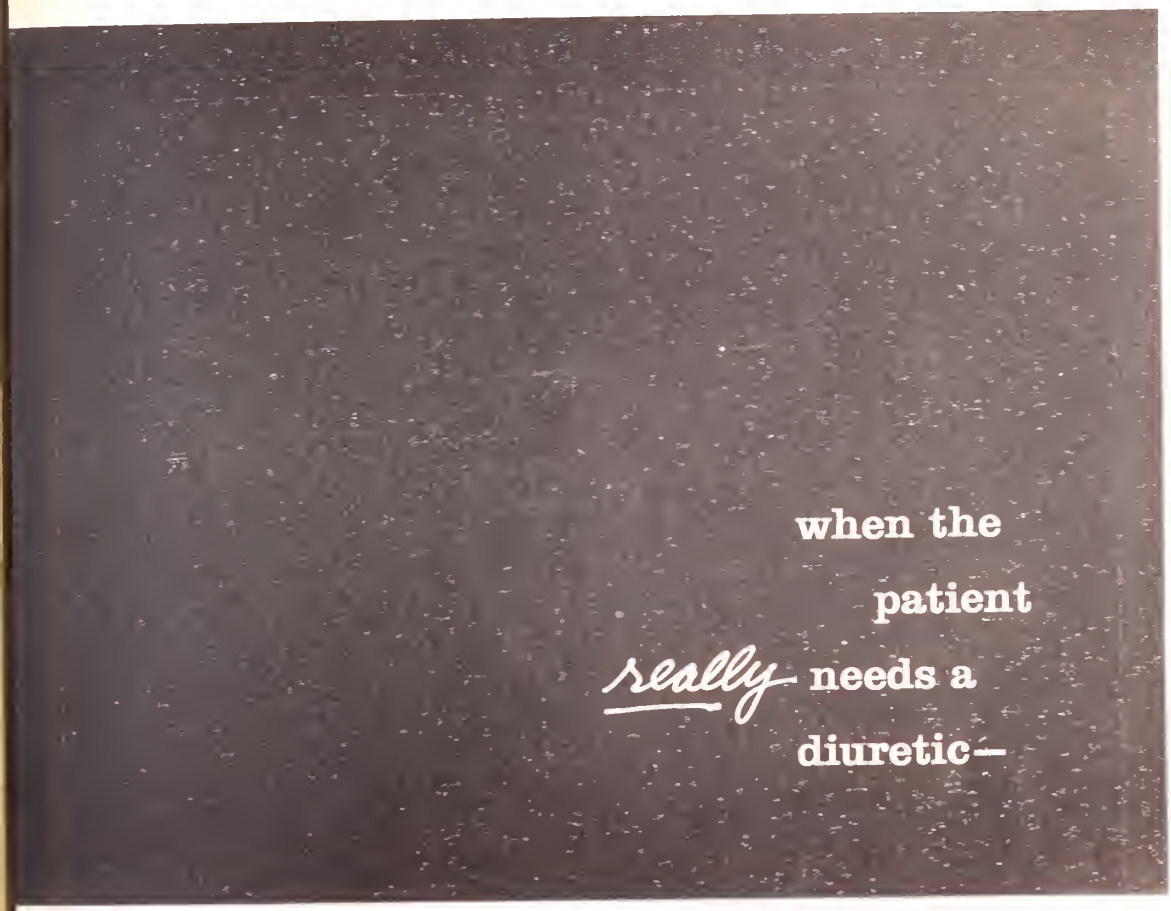
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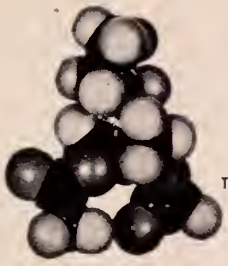
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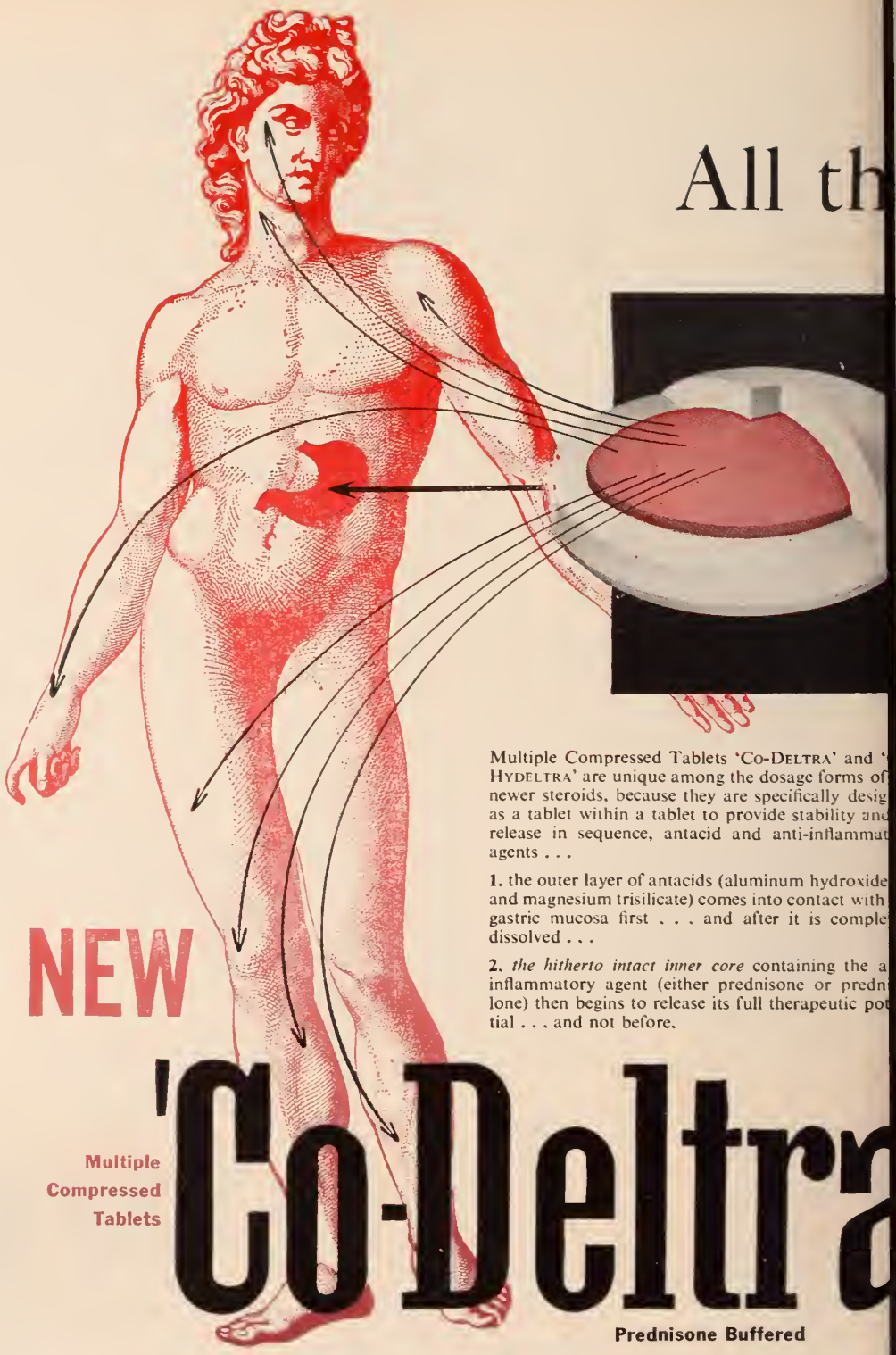
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1. Bollet, A. J., Black, R., and Bunim, J. J.: *J.A.M.A.* 158: 459, June 11, 1955.

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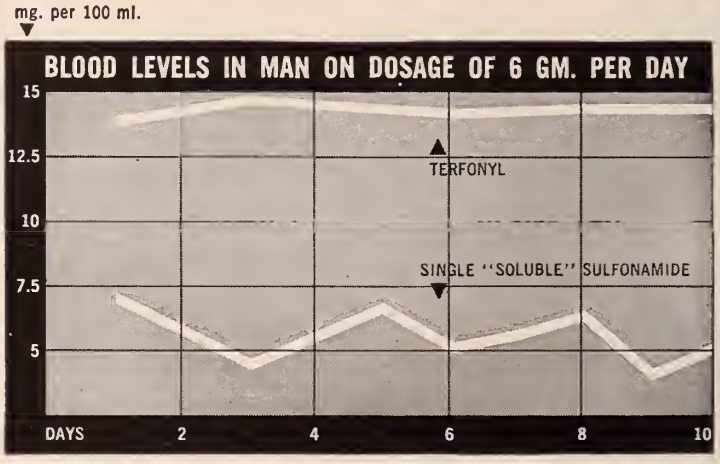
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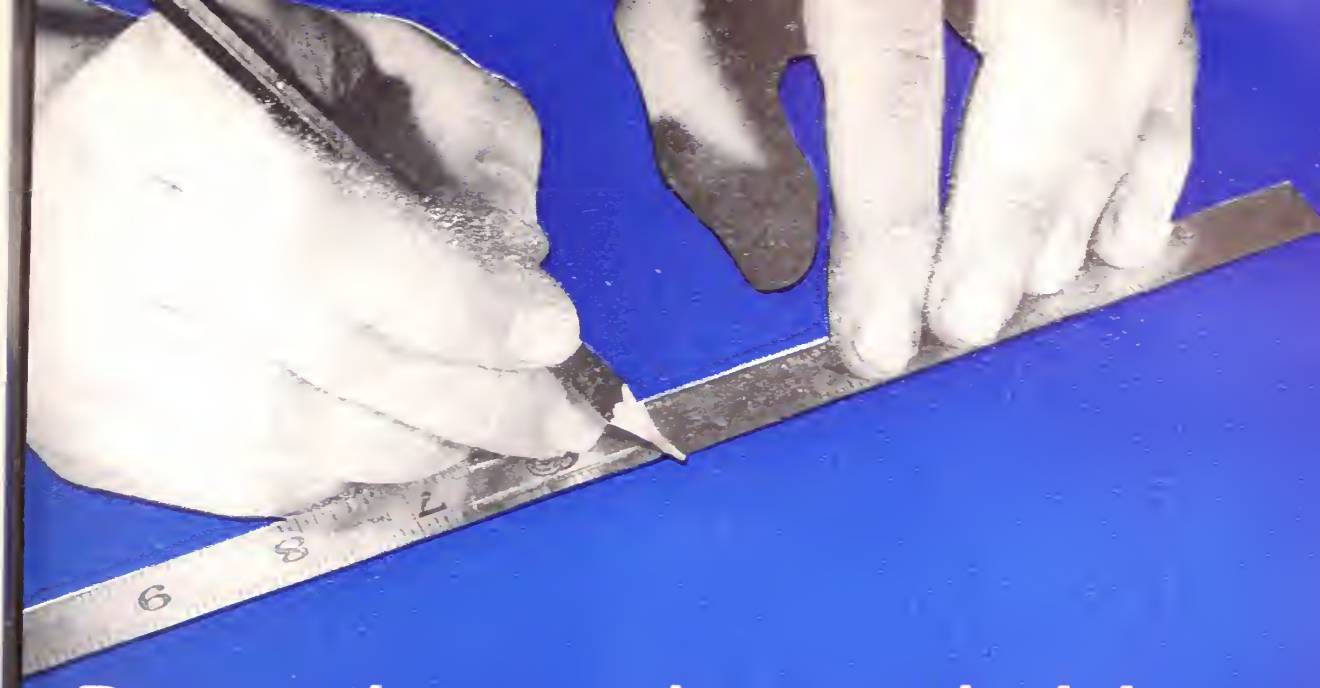
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References: 1. Bunim, J. J., et al.: J.A.M.A. 157:311, 1955. 2. Forsham, P. H., et al.: Paper presented at First Internat. Conf. on Prednisone and Prednisolone, New York, May 31-June 1, 1955. 3. Perlman, P. L., and Tolksdorf, S.: Scientific Exhibit presented at A.M.A. Annual Meet., Atlantic City, June 6-11, 1955.

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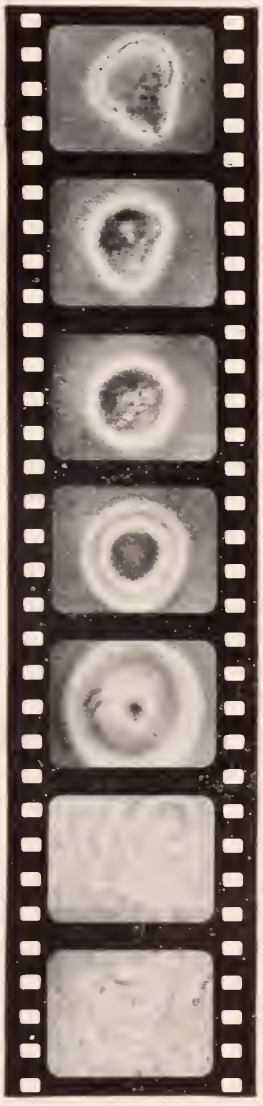
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Top to bottom:
2 sec. CONTACTS
4 sec. COMPLEXES
6 sec. DISSOLVES
8 sec. DENATURES
10 sec. SWELLS
15 sec. EXPLODES
16 sec. SCATTERS

References: 1. Davis, C. H.: J.A.M.A. 157:126 (Jan. 8) 1955. 2. Davis, C. H.: West. J. Surg. 63:53 (Feb.) 1955. 3. Davis, C. H., and Grand, C. G.: Am. Jour. Obst. & Gynec. 68:559 (Aug.) 1954. 4. Davis, C. H. (Ed.): Gynecology and Obstetrics (revision), Hagerstown, Md., W. F. Prior 1955, vol. 3, chap. 7, pp. 23-33.

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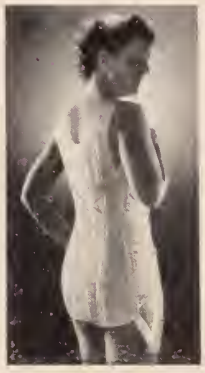
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[1]January, H. L. et al: Clinical experience with tetracycline. *Antibiotics Annual* 1954-55, p. 625.

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Editorials • • •

"For this Relief—"

"He treats the symptoms only" is intended as a term of contempt. A doctor finds himself apologetic if he wants to relieve the symptom before he has worked out the basic pathology. Indeed, a certain amount of snobbery has developed around this. There are medical scientists who feel that anything short of definitive cure is unworthy of their efforts. Such selfless scientists view with ill-concealed disdain the "practitioner" (sometimes the "mere practitioner!") who seeks to relieve his patient's symptoms. Medical education is falling more into the hands of scientists and less into the hands of practitioners. So it seems likely that younger doctors will increasingly concentrate on removing the disease process rather than relieving the symptom.

And in a way this is too bad. Few diseases can be "removed," but most complaints can be assuaged. The doctor who withholds this balm is not giving his patient all that medicine can offer. True, there *are* certain dangers in treating symptoms. For instance, it is argued that if the patient's symptom is relieved, he won't follow through on definitive treatment. But it seems to us that the reverse is equally true. If the doctor does not speedily relieve the complaint, the patient will lose interest in the doctor. It is true that some medications have side-effects, but the danger of abuse is never a sound argument for withholding a benefit.

Anxiety and distress definitely aggravate disease—not only psychically but somatically, not only emotionally but physiologically. To relieve a symptom is to reply to a distress signal. To ignore the symptom is to hurt the doctor-patient relationship. With so extensive an inventory* of drugs, procedures, and technics at the doctor's disposal, there are few symptoms which cannot now be relieved. And to give such solace is surely one of the physician's prime duties.

*Not, you will notice, an armamentarium. See page 511 of the November (1955) JOURNAL.

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High Priced Drugs

"They're called wonder drugs," said the patient, "because you wonder how anybody can afford to pay for them." If one of these new medicaments retails at 15 cents a capsule (and some do), a month's supply will cost $15. This is, perhaps, a low price for a passport to health. But the average bread-winner in America today grosses only $65 a week *before* deductions. He wants to be a self-respecting citizen, not dependent on charity, and completely unwilling to be classed as "medically indigent." If, in good faith, he goes monthly to a doctor who charges $5 a visit, he has no complaint. The fee is modest, the service is of incalculable value, and the right of free choice is worth a good deal. But picture him walking out with a prescription for an antihypertensive agent, a tranquilizer, and a super-vitamin. (In the old days when you called them sedatives instead of tranquilizers they were less expensive). Perhaps he has to pay 12 cents a capsule for the hypertensive agent, 8 cents for the tranquilizer, and 7 cents fo the super vitamin. The month's supply—say 100 capsules of each—now costs him $27. That's more than his income tax withholding for the month, and quintuple the doctor's fee.

What is he going to do about it? At first, he'll grumble. He'll suspect that the doctor must get a kick-back from the pharmacist—for he can't understand those high prices any other way. But as the burden mounts, he will clamor for government help. If government subsidizes farmers and magazines, why should it not subsidize sick people? So he will say if a month's medicine costs half a month's rent.

The doctor is in a bad spot here. The doctor cannot criticize the pharmaceutical manufacturer, because no physician knows what it cost to produce the drug. He does not know whether 7 cents a capsule means an unconscionable profit for the company or whether it is practically giving the drug away as a public service. (He would very much doubt this, however). And he certainly is in no position to challenge the price set by the retail pharmacist, since the physician adheres to the thesis that a professional man is to be trusted to set his own fees.

But whenever a storm breaks in the healing arts field, the physician is always at the epicenter. Whether the storm concerns hospital charges, distribution of Salk vaccine, or the high price of drugs, the public looks to the doctor for corrective action and blames him if it isn't forthcoming. So we physicians do have a legitimate interest in the retail cost of new drugs.

One practical suggestion is to have the pharmaceutical manufacturers drastically reduce their mailings to physicians, osteopaths, pharmacists, and other practitioners. For instance, one company sends out beautiful three-color brochures at frequent intervals. It seems to us as if this mailing comes three times a week, but it's probably not that often. Anyway, to send out 200,000 such brochures must cost at least $15,000. One company recently distributed a hard-cover book reporting a colloquium on its new drug. The book is of $3 caliber. Even if the company got it at half-price, it must have paid out close to a half a million dollars to have that book prepared, printed, bound, packaged and mailed out to all the practitioners in the four corners of this country.

Some poll taker might find out how many doctors drop these brochures unopened into the waste basket. And is it really necessary to heckle the physician day after day with these slick and glossy mailings? An occasional mailing, written with dignity and restraint would not only be cheaper, but would be more effective. The hope is that the money saved by lowering these fantastic promotion costs, might be used to reduce prices to patients. Helping the patient is really the most important activity in the entire healing art field.

The American pharmaceutical industry has built up enormous good will. It has pioneered in pharmacology. It has brought to all of us many life saving and disability-curtailing drugs. In human happiness terms, it is, perhaps, the single most valuable industry in the world. By taking money from patients in order to flood the doctors' desks, it is in danger of frittering away all that good will.

Something to be Thankful For

Among our many blessings, we doctors can be thankful that we are not practicing under a system where the physician has to pay the government if he prescribes an "unacceptable medication." According to a recent JAMA foreign letter* a British physician had to reimburse the government the cost of a sulfur soap for seborrheic dermatitis. The doctor prescribed this, but the lay referees decided that no kind of soap could be classed as a drug, therefore the physician did wrong. So he had to shell out and pay the government the cost of the sulfur soap! Another British practitioner had to pay back for prescribing protein hydrolysate for ulcerative colitis. Although an accredited specialist told the "executive council" that this was sound medication, the lay referee's decision was that no specialist had any right to tell the executive council what medications could be provided under the National Health Act.

We find lots of faults with our system here. But if any doctor would like a quite different system, there is always an opportunity in Britain. Any takers?

Self Criticism—Unlimited

Honest confession is good for the individual soul. But when a whole professional group wraps itself in sackcloth and ashes, it gets very confusing. As an over-reaction to the "doctor knows best" philosophy, many of our brethren as well as many of our critics have taken to writing of the evils of medical practice. One national magazine advertised an arbeit coyly captioned "some doctors should be in jail." And one of the slicker periodicals had an essay last year on fee splitting which seemed to indict a lot of surgeons. There have also been articles on unnecessary surgery, exorbitant fees, reluctance to serve the indigent, and, of course, a veritable parade of polemics on the doctor's politics.

Another recent instance is the article "Superman is a Myth" by the Evansville (Indiana) reporter, Edward Klingler. His article—which is approved by the Indiana State Medical Association—calls on doctors to "stop regarding themselves as supermen," pointing out that physicians have normal human foibles. And anyone can find a dozen other attempts, often medically supported, to down-grade the M.D. (We don't deny the human foibles. We simply wonder if it is good to boast of them).

The unfortunate effect of all this well meant breast-baring is obvious. When we doctors participate in it, it may be due to our inherent masochism. But it is rationalized on the theory that this self-criticism shows how open-minded we are. In terms of the individual practitioner's prestige, this is not a healthy trend. And there is something even more important than our individual prestige. That is the patient's welfare. Here the net effect has been to make many people suspicious of the competency and motives of their doctors. For example, the distinguished Evanston gynecologist, Charles E. Galloway, recently reported an excessive amount of resistance to necessary pelvic surgery. This, he says, is due to garish publicity which has made many women feel that the operation may be medically unjustified. Similar examples of refusal to cooperate could be cited in every branch of medicine. Thus, this moan of *mea culpa* is not only damaging the doctor . . . what's worse, it's hurting the patient.

*Page 1789 of the Dec. 31, 1955 Journal of the American Medical Association.

DANIEL BERGSMA, M.D., M.P.H.
Trenton

Public Health Aspects of Poliomyelitis*

Few events in modern medical history have been as dramatic as the development of the Salk vaccine. In this well-reasoned, down-to-earth presentation, our state's Health Commissioner gives our readers a compact run-down on the problem.

BETWEEN January 1 and September 17, 1955, there were reported to the New Jersey Department of Health, 416 cases of poliomyelitis. Analysis of these cases by county shows a distribution comparable to the difference in the populations fo the several counties. There was no area epidemic within the state during that period.

The age group 5 through 9 sustained the highest attack rate. This has been true in previous years and accounts for the decision to limit the use of the short supply of vaccine for individuals in this age group until their greater need for protection has been satisfied. The age groups one through four and ten through fourteen had reported 58 cases and 69 cases respectively. The group between 15 and 19 inclusive had 40 cases. The age group 20 through 24 had 23 cases and the group under one year of age had only 4 cases reported. This is the usual distribution by age in this state for poliomyelitis and suggests that the age group under one is less in need of protection with poliomyelitis vaccine as compared with any other individual age group between one and twenty-four years of age.

As the vaccinations were proceeding in the western states, poliomyelitis was reported among children who had been injected with the vaccine of one manufacturer. This could have resulted from any of these reasons:

1. The individual was infected before he had the injection.
2. The individual was infected before the vaccine had time to produce adequate antibodies.
3. The individual was one in whom the vaccine was not effective.
4. The vaccine contained live virus.

Analysis of data suggests that all four reasons played a part in the officially reported cases of poliomyelitis diagnosed among persons who had received an injection of poliomyelitis vaccine produced by this one laboratory.

Epidemiologic evidence routinely collected by health agencies quickly indicated a cause and effect relationship between the cases of poliomyelitis and the use of certain lots of vaccine from this one manufacturer. The Public Health Service recommended a temporary suspension of all poliomyelitis vaccination programs pending the reappraisal of testing procedures with respect to the safety of the vaccine.

About 1800 cubic centimeters of the questioned vaccine had been sent into New Jersey and about 280 were actually used before the rest was returned to the manufacturer. No cases of poliomyelitis appeared among those few who did receive this vaccine in this state.

* Presented before the Northern District Public Health and Sanitary Association at Dover, New Jersey on September 21, 1955. Dr. Bergsma is New Jersey's Commissioner of Health.

INACTIVATED VS. ATTENUATED VACCINES

Some of the controversy concerning Salk vaccine centered about its risks in comparison with other vaccines being used experimentally or which might some day be developed. However, the Salk vaccine, prepared in the intended manner, had a good capacity to induce antibody production to the three known types of poliomyelitis virus. One of the most outspoken opponents of the Salk vaccine championed his own product for which a high antibody production was claimed but unproved in terms of adequate field trial and which was admittedly a live attenuated product.

The original data of Dr. Salk suggested that a complete inactivation of virus was possible in the laboratory. When the manufacture was done on a large scale, difficulties were encountered in keeping the mixtures sufficiently homogeneous to permit every particle of virus to be exposed adequately to formalin.

The Brodie and Kolmer vaccines which had brief and disastrous trials in 1935 were of the incompletely inactivated and attenuated type. These experiences, together with those which occurred in the early part of 1955 vaccination programs, will certainly influence physicians to *use vaccines which are as completely inactivated as it is possible to produce*. One problem still under study is alternate methods of complete inactivation without loss of antigenic potency.

VACCINATION PROGRAM IN 1955

Poliomyelitis vaccine which had passed the revised safety standard was released to New Jersey and the program got off to a delayed start. This was unfortunate because the vaccine had been adequately retested in the laboratory and it had undergone an even more important and successful field trial. The Eli Lilly product assigned to New Jersey had already been administered to more than 2,300,000 children in 14 southern states without unfavorable reaction. These human guinea pigs, and I use the term very affectionately, rendered an incalculable service in proving the safety of the vaccine and one can only hope that their special reward will be a durable immunity to the paralytic effects of poliomyelitis.

It was this knowledge of both laboratory and field experience that prompted me, in the face of a great deal of resistance from ill-informed sources, to urge communities to proceed with their vaccination programs before the closing of schools. Time was of the essence and the telegram to all health officials was purposely worded with great clarity and force to counteract the inertia which was increasing. We are grateful that 71,033 eligible children received their first injection; that 25,659 received their second injection; and that 3,414 children received their booster injection to date.

Enough vaccine is available to complete the second round of injections. Communities are being urged to get their programs underway soon and to complete the injections before the end of October. No first injections will be given with National Foundation vaccine to those who declined the injections earlier.

EVALUATION OF PROGRAM

Preliminary reports from several states seem to indicate a trend for lower attack rates among vaccinated children than among unvaccinated comparison groups; and also a tendency to milder illnesses. In most cases, higher proportions of cases occurring among vaccinated children have been non-paralytic, suggesting a possible modifying effect.

SURVEILLANCE UNIT

One of the benefits of the unfortunate occurrence of poliomyelitis resulting from certain few vaccine injections, has been the establishment of a poliomyelitis surveillance unit by the United States Public Health Service.

Through the Georgia laboratory at the Communicable Disease Center and other cooperating laboratories throughout the country, confirmation of selected cases reported as poliomyelitis is now possible.

It has always been difficult to establish a certain diagnosis of poliomyelitis. The abortive types of poliomyelitis (which clear up completely without recognizable residual effects) cannot be diagnosed without recovery of the virus from stools or without evidence of a rising antibody level. Even the paralytic cases require the same studies to distinguish poliomyelitis from other diseases with which it can be confused.

The laboratory diagnosis of poliomyelitis will assume increasing importance in evaluating the efficacy of vaccine and a great effort is being made to obtain appropriate specimens from reported cases of poliomyelitis that have received vaccine or are in the household of vaccinated cases.

It would be valuable if all physicians would report the paralytic or non-paralytic and the vaccination status of all cases of poliomyelitis at the time of the initial report.

PROVOCATIVE INJECTIONS

Most physicians advise that injections against diphtheria, pertussis and tetanus be postponed during periods of high poliomyelitis incidence unless the risk of the disease to be prevented is greater than the presumed risk of converting an asymptomatic poliomyelitis infection into a paralytic one or of localizing the paralysis to the site of the injection. Experiments show that the "provoking" effect of injections is greater when relatively unrefined materials are injected.

Poliomyelitis vaccine is largely a balanced salt solution with only traces of formalin-treated protein. The quantity or volume of virus, plus the foreign non-antigenic protein in the polio vaccine, required to produce an immune response in man, is far less than the comparable volume of bacteria plus associated foreign proteins found in microbial antigens.

No significant "provoking" effect could be demonstrated during the mass injections of gamma globulin and gelatin control injections at the time Sioux City was having a high incidence of poliomyelitis.

No provocative effect was observed among the 2,300,000 children injected with poliomyelitis vaccine in the 14 southern states as referred to earlier.

The injection of Salk vaccine must be considered in an entirely different light from the possible effect of injected materials which do not produce an immune response against poliomyelitis infection itself. The vaccine is expected to produce some antibody as early as a week or ten days following the first injection and even small amounts of antibody will neutralize the provocative effect and may also be expected to have some effect in preventing paralytic poliomyelitis after this interval of time.

VACCINE DURING RISING INCIDENCE

The preventive effect of the vaccine in a period of rising poliomyelitis incidence should be much greater than the possible hazard from the provoking effect of the injection. After the tenth day following injection, most vaccinated individuals would be protected sufficiently to ward off some of the paralytic effect of poliomyelitis even after only one injection.

I mention this because we may go through a period of hesitancy to administer vaccine between now and next summer if some physicians do not accept the above information and convey this to parents.

HOW LONG DOES IMMUNITY LAST?

Some of the children who received the first injections of the Salk vaccine by Dr. Salk himself are still being studied in terms of antibody levels. In most individuals, detectable amounts of antibody for all three types of poliomyelitis virus appear, when none was there before, between the seventh and eleventh day following the first inoculation. This rises to a plateau at about the twelfth day. When a second inoculation is given between the second and fourth week following the first inoculation, a greater rise in antibody levels occurs about a week after the second inoculation. The antibody level reaches a higher plateau ten

days after the second inoculation. If no further inoculations are given, the antibody levels slowly recede but persist in measurable amounts for many months. Most such individuals show significantly high amounts of antibody for as long as they have been studied to date, which means two years or more. If a third inoculation is given within two weeks of the second and within four weeks of the first dose, many such individuals prove to be in a refractory stage and they do not respond by more antibodies. The third inoculation can serve most effectively as a booster dose if it is given at least five months after the second inoculation and perferably seven months after the second inoculation. The third inoculation continues to act as a booster even if given a year or more after the second inoculation. In most people, a high titer of antibody in the blood for each of the three types of poliomyelitis virus is complete or very significant protection against severe paralysis from the disease.

Evidence suggests that the poliomyelitis virus (as transmitted in nature) may not only infect individuals who are completely susceptible to the disease and also make temporary carriers of them; it may also infect persons who are immune to the paralytic aspects, and make temporary carriers of them. Presumably, in this disease, such sub-clinical re-infection exercises a booster effect to the immune person so infected.

Dr. Salk has made the following statement: "If vaccination induces an alteration in the immunologic mechanism, then subsequent contact with the poliomyelitis virus under natural circumstances should cause antibody formation to begin sufficiently rapidly and might be expected thereby to increase the likelihood that long-lasting immunity will follow the proper use of a properly constituted vaccine."

POTENCY OF 1955 VACCINE

A NUMBER of field studies are now under way which should tell us something of the potency of the 1955 vaccine. Results will be available during the next few months. In the summer of 1955, Massachusetts had a significantly high incidence of poliomyelitis, and a semi-final report from that state shows an unmistakable difference in the disease rate among vaccinated and unvaccinated children. In terms of rate per 100,000, here are figures:

24,000 children who had 2 inoculations: 8 cases per 100,000

150,000 children who had 1 inoculation: 28 cases per 100,000

285,000 unvaccinated children: 150 cases per 100,000

You do not have to be a statistician to see that a difference between a rate of 8 and a rate of 150 is meaningful. This preliminary report suggests that the vaccine is very potent; that one inoculation is far better than none; that two inoculations are distinctly better than only one. It suggests that the recommended vaccination program of three doses properly spaced would eliminate most of paralytic poliomyelitis among the properly vaccinated groups. The unvaccinated children experienced over five times as high a rate of poliomyelitis as those children who had received only one inoculation. Unvaccinated children had over eighteen times as much poliomyelitis as children who had had the benefit of two inoculations.

NEW JERSEY STATE REGULATIONS

THE Department of Health here is authorized to purchase poliomyelitis vaccine and to establish regulations to achieve the equitable distribution and use of the vaccine.

Copies of the regulations have been sent to each practicing physician in New Jersey together with information regarding the eligible age groups and the required record keeping.

As of September 21, 1955, by both federal and state regulation, the age group five through nine years of age, is the only group eligible to receive any of the poliomyelitis vaccine while it remains in short supply as declared by the State Department of Health.

Record keeping in physicians' offices includes notation of the name of the manufacturer and lot number, the name, address, and age of

each person inoculated, the site and date of inoculation.

DISTRIBUTION OF VACCINE

UNDER a voluntary agreement, all manufacturers send to the Department of Health a copy of every shipment made into New Jersey whether to a physician, pharmacist, supply house, or state or local tax supported agency. Pharmacists and supply houses report weekly concerning specific amounts on hand and dispensed.

The Department of Health, upon recommendation of the New Jersey Advisory Committee, has requested that of all allocations of vaccine to New Jersey, the State and other tax supported agencies receive 25 per cent. The remaining 75 per cent goes to practitioners and their usual sources of supply. If for any reason, New Jersey does not use all the vaccine it is equitably entitled to, we might lose the balance through re-allocation to other states. State-purchased vaccine is placed in the 65 "biologics" distribution stations throughout the state from which physicians may obtain the vaccine without cost for use on eligible children who would otherwise be deprived of this preventive measure because of the cost.

Vaccine made available to the State under federal law will be placed in the distribution stations and made available to municipalities for immunization clinics under the federal law.

The State has a responsibility of assuring that all children have an equal opportunity to be protected from poliomyelitis.

The medical profession of New Jersey has repeatedly indicated its willingness to provide whenever indicated at reduced cost (or at no cost) the medical services involved in the process of immunizing children of this state against preventable diseases. The State in turn has pledged itself to provide certain available biologic products for this purpose free to physicians for such individuals.

Parents who can readily pay for vaccine and associated medical services can arrange for the injections in the offices of their private physician. If the physician believes it is necessary to modify his own fee, he can further assist parents by obtaining the vaccine without cost at any of the distributing stations.

AGE GROUP PRIORITIES

DURING the period of short supply, only children in the ages of five years through nine years are eligible to receive poliomyelitis vaccine. This age group priority was established by the National Advisory Committee on Poliomyelitis. It is also a requirement of the regulations set up under statute by this Department. The age span of eligibles will be expanded to include less susceptible individuals as quickly as the available supply is adequate to satisfy the need and desire of the most susceptible group with the highest attack rate, namely those five through nine years of age.

THE STATE HOUSE

E. N. Murray, M.D.
Camden

Myocardial Infarction*

With Emphasis on the Shoulder-Arm-Hand-Pectoral Syndrome

Eschewing all theoretical discussion, Dr. Murray presents here in simple, matter-of-fact fashion, his clinical observations on 211 cases of myocardial infarction. The author also reviews the oft-neglected Shoulder-Hand-Pectoral Syndrome.

THIS is a survey of 211 consecutive private cases of acute myocardial infarction. They were treated at the Cooper Hospital in Camden, N. J. between 1951 and 1954. Emphasis is placed on the shoulder-arm-hand-pectoral syndrome but other complications are discussed and diagnostic and therapeutic procedures are considered. Of the 211 patients, 155 (70 per cent) were men.

Mortality rate was 21 per cent. All deaths are included—even that of a man who succumbed ten minutes after admission to the hospital. Postmortem examination was performed in 15 cases.

ACCOMPANYING CONDITIONS

OF THE 211 patients, 24 had diabetes. Three of the 56 women had hypothyroidism. Twenty-six of the last hundred had emphysema. This is mentioned because of recent interest in the possibility that one of the causes of diffuse emphysema may be bronchial artery sclerosis and narrowing with resulting loss of nourishment to the elastic framework of the lung. Only one of 211 patients had a positive serology. He also had aortic insufficiency, central nervous system syphilis and a cord bladder.

*Read April 20, 1955 at the Annual Meeting of The Medical Society of New Jersey in Atlantic City.

CLINICAL OBSERVATIONS

MIDLINE involvement by the coronary pain was almost universal. Only six cases of the 211 did not have pain in the midline.

Radiation of the chest pain to the *jaw*, though less frequent than radiation to the arm, appears to me to be more pathognomonic of coronary disease than does arm radiation. It also seemed to indicate a graver prognosis. Jaw pain occurred in 17 of the 211.

Similarity of the attack of myocardial infarction to previous attacks of *angina* of effort was often striking. It is advisable to ask the patient about this. He frequently replies that the location and the type of pain are the same as he has previously experienced when walking. He will then often go on, with direct questioning, to say that the attack under consideration (infarction) began while he was at rest, is more severe, has already lasted much longer, compelled activity (sitting up, standing up, or walking); whereas the old angina compelled him to stop on the street.

The *sedimentation rate* was rapid in 209 of the cases. It was common to have to wait two, three, four or even five days for this abnormality to appear.

Rising blood pressure occurred only 14 times in the 211 cases. Its frequency is still not

generally appreciated but it obviously does occur, although it may be transitory. Of course a *drop* in blood pressure was seen much more often (shock in 37 per cent of our cases).

THERAPEUTIC NOTES

ANTI-COAGULANTS — Bishydroxy coumarin† was administered to 190 patients and heparin to 192. Among the patients receiving the coumarin,† bleeding occurred in 16 patients (7 per cent). There were no fatalities. Fourteen of these 16 bled from the urinary tract and two from the gastro-intestinal tract. Since vitamin K_1 emulsion for intravenous use has been available, no blood transfusions have been needed—so rapid and so efficient has been the effect of this preparation in raising a low prothrombin per cent.

Nor-epinephrine repeatedly demonstrated its ability to combat shock and so did lanatoside-C on a few occasions, though the latter agent [1] was used *only* in those patients who decompensated. The lanatoside-C was given in the form of Cedilanid (a registered Sandoz tradename).

COMPLICATIONS

SHOCK occurred in 75 cases, that is, 30 per cent.

Decompensation occurred in 56 cases, that is, 26 per cent. I treated it with digitalis, salt restriction, and sometimes with mercurial diuretics.

Pericarditis: This was noted in 40 of 211 cases. Pericarditis was detected by friction rub, electrocardiogram, or by postmortem examination. The pericarditis sometimes involved an area which was larger than that of the infarct. This is interesting in view of the non-specific pleurisy and upper abdominal peritonitis which sometimes occur with myocardial infarction.

Rupture of left ventricular wall occurred in one case. It was verified by autopsy. This occurred on the twelfth "post coronary" day. The patient was not receiving an anti-coagulant at the time.

Perforation of inter-ventricular septum occurred in one case, verified by autopsy. In this case the thrill and the murmur were best detected at the apex rather than medial to it. According to Friedberg [2] "the perforation is usually a single one in the lower or central portion of the septum." "The diagnostic feature is a loud systolic murmur which is usually loudest in the fourth and fifth interspaces near the left border of the sternum. A systolic thrill is almost always present in the same area." The apical location of the murmur in our case may have been due to the extreme apical situation of the hole.

SHOULDER-HAND-PECTORAL SYNDROME

THE shoulder-arm-hand-pectoral syndrome occurred in 55 cases. This amounted to 26 per cent of the series. I have purposely included the "pectoral" part of this syndrome. Spots of pain and *tenderness* in the pectoral regions frequently occur soon after a myocardial infarct. And this has often given rise to unnecessary anxiety in the patient, the resident staff, and the attending physician. However, the pain of pectoral "myositis" can usually be differentiated from the pain of myocardial ischemia. Pectoral "myositis" (that is — the pectoral part of the shoulder-arm-hand-pectoral syndrome) does not involve the midline; it is usually tender; it is often exaggerated by movements of the upper extremities. One such patient, several weeks after discharge, went on to develop a puckering of the skin over the left pectoral region when he abducted his left upper extremity. It appeared as though a subcutaneous fibrous band, about 5 inches long, was pulling the skin inward and cephaled when he raised his arm.

The shoulder-arm-hand-pectoral syndrome is said to have at least two possible etiologic factors. One theory [3] holds that impulses over-

†This was given as Dicumarol®, a registered tradename of the Wisconsin Alumni Research Foundation.

1. Harrison, T.: Yearbook of Medicine — 1954-55 Series. Pg. 397. Chicago 1955. Year Book Publishers.
2. Friedberg, C. K.: Diseases of the Heart. Pg. 457. Saunders. Philadelphia 1950.
3. Johnson, A. C.: Disabling Changes in the Hands, Following Myocardial Infarction. Ann. Int. Med. 19:433 (1943).

flow the upper thoracic and lower cervical spine segments at the time of the coronary attack, with resulting vasoconstriction in the upper limbs. Some proponents [4] of this theory note the occasional occurrence of palmar vesicles as early as the first or second post coronary day. Wolferth and Edeiken [5] point to the similarity to causalgia. Another theory [6] is that the chief cause of trouble is protective disuse of the upper extremities. It seemed that the disuse theory was more applicable in the present series. Painful, tender and stiff shoulders, arms, hands and pectoral muscles were observed more often among patients who "splinted" their upper extremities and chests because of a painful complicating pericarditis or because of a marked degree of anxiety.

Prevention of the shoulder-arm-hand-pectoral syndrome seemed to be partly achieved by the routine employment of hourly abduction of each upper extremity. Patients were made to reach up over the head with one arm and grasp the opposite ear with the thumb and forefinger of the abducted extremity. These procedures were usually started on the second or third day.

Treatment of the syndrome consisted of aspirin for its analgesic and its ACTH-like effect, of passive motion and active motion of the arms, of stellate block, of procaine injections [7] into tender pectoral spots in two cases, and of the administration of cortisone to two patients.[8] Oral hydrocortisone may be the treatment of choice, and even Meticorten® is now being tried. Oral hydrocortisone and Meticorten® were not available when the patients of this series were hospitalized.

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4. Shapiro, E. L. and Kohn, J.: Trophic Ulcers of Hands Complicating Myocardial Infarction, Am. J. Med. Sciences, 214:288 (1947).

5. Edeiken, J. and Wolferth, C. C.: Persistent Pain in the Shoulder Region Following Myocardial Infarction, Am. J. M. Sciences, 191:201 (1936).

6. Ernstene, A. C. and Kinell, J.: Pain in the Shoulder as a Sequel to Myocardial Infarction, Arch. Int. Med., 66:800 (1940).

7. Swan, D. M. and McGowan, J. M.: Shoulder-Hand-Syndrome Following Myocardial Infarction, Treatment by Procaine Block of Stellate Ganglion, Journal of the Amer. Medical Association 164:774 (1951).

8. Russek, A. I., Russek, A. S., Doerner, A. A. and Zohman, B. L.: Cortisone in the Treatment of the Shoulder-Hand-Syndrome Following Acute Myocardial Infarction, Arch. Int. Med. 91:487 (Apr. 1953).

130 North Broadway

Some Fat People Should Not Lose Weight

Certain overweight people do not lose weight despite dieting, and should *not* diet. The special pattern of food intake is termed the "Night-eating Syndrome" and is reported by Stunkard, Grace and Wolff of the Cornell Medical Center, in the July 1955 *American Journal of Medicine*.

Study of 25 obese patients revealed that eating patterns of a large number were similar. Further details showed the night-eating syndrome to be comprised of three primary characteristics: (1) large amounts of food are consumed during the evening and night, a period "when the food intake of non-obese people is negligible"; (2) insomnia; and (3) loss of appetite in the morning with little food intake at breakfast. The syndrome was noted to occur during periods of weight gain and periods of life stress.

The syndrome "is not a result of weight gain, overeating or any metabolic consequence of these. The syndrome appears to represent a response to stress of a type peculiar to certain obese patients, and one intimately related to the overeating which leads to their obesity."

Obesity due to emotional disturbance should not be subjected to diets because of patient reactions. The syndrome may be useful to indicate "that it will be very difficult for him to lose weight, and that he may attempt it only at a risk far outweighing the benefits to be derived." The syndrome may also be of use "as an index of the success of psychotherapeutic measures."

H. C. Goldberg, M.D.
Plainfield

Practical Patch Testing†

In easy-to-follow language, Dr. Goldberg details the technic of the patch test. The chart and the instruction sheet are unique contributions and will be found very helpful.

The patch test is the most valuable test available for detecting the cause of dermatitis venenata, allergic eczematous contact-type dermatitis, and sensitization dermatoses. It is at hand for anyone familiar with it. It is a reliable, precise, useful agent when used and interpreted properly. Recently an extensive series of these tests was used to determine the sensitivity of the skin to a new preparation tradenamed Sebizon Lotion®. The methods selected to test this can be used to find and eliminate any contact suspected of causing an eruption on the skin.

The reaction in the patch test takes place in the epidermis. It is of little value in the search for substances which cause dermal reactions in the cutis such as urticaria. These are linked with systemic immunologic responses. Poison ivy is a familiar skin irritant, and its chief manifestations are erythema, blisters and oozing on the epidermis. Shellfish frequently cause skin reactions such as hives and edematous papules affecting the dermis or corium. A patch test can be done satisfactorily with the former but not the latter.

It is necessary to determine that we are actually dealing with an eruption caused by an external agent. This may be either a primary irritant such as iodine or sulfuric acid, or one to which the skin has become sensitized such as a metal bracelet or wrist-watch. In the acute phase both types usually cause an eruption characterized by redness, papulation and blisters of varying degree accompanied by itching and appearing chiefly on the areas most directly exposed to the suspected agent. In the chronic phase thickening and scaling of the skin frequently occur. It is necessary to rule out diseases not caused by skin irritants; these include eczema, fungus diseases, seborrheic dermatitis, infectious processes, drug eruptions and many rarer conditions.

Site of the eruption is one of the most important aids in making a diagnosis of a "contact dermatitis." This often appears on exposed symmetrical areas of the body when the irritating agent is sprayed or air blown or on a part of the body in contact with an article such as a metal slip strap clip involving the upper part of the chest or the eye glass frames involving the face and ears. The information obtained from the questionnaire* (Chart I) is as important as the clinical appearance of the skin in arriving at a diagnosis. Both together lay the ground work for isolating contactants. The often crucial point of compensability is established by determining the time during which the eruption may have been caused, and by patch testing the patient with

†The work here reported was done in part through a grant furnished by the Schering Corporation of Bloomfield, N. J. The Schering Corporation also furnished the lotion used in this study.

*The questionnaire—see page 168—may be reproduced with spaces for the patient's answer; or the form as printed on that page may be used as a guide by the physician.

the agents contacted during this implicit time-period. Eruptions due to primary skin irritations or allergic skin reactions resulting from work contacts are both compensable. The patch test should not be used with known primary irritants. Eruption follows contact by some definite time interval. In general the milder the irritation caused by the contact agent, the longer will be the response time interval. A mild cutting oil irritation on a machinist's forearms may not manifest itself until the latter part of his work week. This may then without active treatment subside over a week-end only to reappear again after several days of contact with the splashing oil. By contrast, contact with poison ivy may within an hour or two develop an eruption in very susceptible individuals. The diary (Chart 2) when faithfully kept gives valuable information that often spells the difference between success and failure in finding and identifying a contact irritant. No man can be familiar with the endless variety of things each individual has occasion to handle, but this can be determined from a list of contacts and activities of the patient. This problem is of such daily interest and importance that a recent text-book[1] has been published to show the common sites of an eruption and the associated suggested causes.

TECHNIC

THE patch test is most valuable to the practicing physician for identifying the cause of an allergic eczematous dermatitis; to the researcher for determining the sensitizing potential of a new drug and for answering other investigative problems.

Allow an extensive, severe eruption to subside before doing patch testing both to guard against a flare-up of the eruption and to have a reasonably normal skin for the testing. Almost any part of the skin can be used for testing purposes. Practical considerations have established the upper outer arm, the forearm, and the upper back as the most suitable areas. The patch test is left on the skin for 48 hours. The patient is told to remove the test earlier if undue irritation is caused.

Except as below indicated, the suspected substance may be generally used in the strength in which it is encountered. A primary irritant such as nitric acid should never be tested. Many substances can be diluted according to standard tables[2] when allergenic factors are of special interest to the investigator. The purpose[3] of the patch test is to apply the suspected substance to the skin for a definite period of time simulating actual contact conditions and to determine what reaction occurs. The test substance is placed on a non-irritating material such as paper, cellophane, or muslin, which is then applied to the skin. It is held in place with adhesive tape. A large Band-aid® serves admirably to accomplish this, although specially prepared patch test strips are obtainable. The strip holds the test material in an occlusive manner firmly against the skin. A drop or two of water should be added to dampen any dry test substance. It is essential that the skin site be normal. In 48 hours the strip is removed and the tested skin is ready for inspection.

To determine whether a new drug or material will cause a sensitivity to develop, the prophetic patch test[4] offers the best help. In this, the prepared patch is applied to an easily identified skin site such as the upper forearm just below the biceps tendon. Since an incubation period is necessary for true sensitivity, no reaction should occur in the first 48 hours with the first part of this test unless a prior exposure has taken place or unless a primary irritant is inadvertently being tested. Three weeks later the test material is again patch-tested on the precise area previously used. Then, if no reaction occurs in 48 hours, no sensitization has developed. The Food and Drug Administration requires that 200 persons be tested without a single positive reac-

1. Epstein, E.: Regional Dermatologic Diagnosis, Philadelphia, Lea & Febiger 1950.

2. Sulzberger, M. B. and Baer, R. L.: Year-Book of Dermatology & Syphilology 1943 p. 25. Chicago Year Book Publisher.

3. Schwartz, L., Tulipan, L. and Peck, S. M.: Occupational Diseases of the Skin, ed 2, Philadelphia, Lea and Febiger, 1947.

4. Traub, E. F., *et al.*: Evaluation of Dermal Sensitivity, Arch. Dermat. & Syph. 69:399 (April) 1954.

CHART 1

PATCH TEST QUESTIONNAIRE

1. Do you know what makes you worse? Foods? Contacts? Illness?
2. Worse at certain times? Day? Night? Season? Week-days? Week-ends?
3. Environment. Apartment house? 1-family? multiple family? insects? mosquitoes? moths? garden flowers in house? insecticides for rats?
4. Household pets? (cats, dogs, canaries, goats, horses, and so forth).
5. Bedroom: pillow, mattress; comforters, afghans, blankets, sachets, contraceptives?
6. Living Room: upholstery? stuffing? heating? air-conditioning?
7. Laundry: soap powders? detergents? insecticides?
8. Bathroom: soaps? cosmetics? bath salts? tooth pastes? hand cleansers? shaving preparations? hair tonics? hair dressing?
9. Cosmetics: perfume? toilet water? wave set? lacquer? deodorants? douches? nail polish? costume jewelry? vaginal preparations? beauty parlor treatments? Indicate brands of cosmetics at home.
10. Children: gum, cosmetics, fruit, toys, tonics?
11. Medications: for acid? for headache? for insomnia? for nerves? for constipation? for coughs? for itching? Do you use aspirin? Bromo-Seltzer®? Alka-Se'tzer®? vitamins? Anacin®? Bisodol®? laxatives? barbiturates? other medicines?
12. Occupational Contacts: at work? at play? What hobbies? Work or play with chemicals? photography?
13. New clothing: pajamas? underwear? gloves? sweaters? furs? socks? shoes? eye-glasses?

CHART 2

INSTRUCTIONS ON HOW TO KEEP A SKIN-CONTACT DIARY

Purpose of the diary is to find *all* the substances with which your skin comes into contact. This contact may occur at work, at play, at your hobby, at your home, at friends', or in public places. The contact may be direct, as for example when an eye-glass frame touches the skin behind the ear and inflames it; or indirect as when a perfume scent inflames the skin.

Only by writing down *all* of these contacts can suspected substances be eliminated from aggravating your skin condition. This means thoughtfulness, time and effort in making your diary comp'ete. The value of your diary depends entirely on its completeness. A diary which is 90 per cent complete and accurate may leave out the other important 10 per cent in which your allergic agent is involved. Nothing, however small it may seem, should be omitted!

The diary is kept in a time order. This is important. Make records as often as possible to avoid forgetting notations. It should be done at least after each meal and before going to bed.

On the *left* side of the diary, record all contacts and activities, and the day, date, and time at which they are made. This includes foods eaten, and clothing worn, in addition to the other previously mentioned factors.

Things other than foods need not be noted more than once. Bring diary each visit.

On the right side of each page, record only such occasions as when the skin condition is irritating, or itching more than usual. The time when this occurs should be noted carefully. This notation should be placed opposite the same time as is written on the left or contact side of the diary, for example:

CONTACTS OF THE SKIN *Day, Date and Hour*		REACTIONS OF THE SKIN *Note the Time*
7:00	Blue cottion pajamas, leather bedroom slippers and red woolen bathrobe, Squill tooth powder, Kremo hair tonic, ivory soap	
8:00	Breakfast, orange juice, toast, marmalade, coffee	
9:00	Sprayed insecticide in closet (Flit?)	
9:30	Polished furniture with John's Polish	9:30 Corners of mouth and chin felt worse than when I got up (due to toothpowder? soap? orange juice or Flit?)

ion before releasing a new product. Most drug companies will test thousands rather than a few hundred persons to assure themselves that a new product is safe for topical application. In the past, drugs have been tested on a few hundred persons and erroneous conclusions reached. In dealing with such small groups, serious errors can be made where we may be testing products to which only one person in 100,000 may react. In such instances statistical analysis[5] is of great help. Rostenberg[6] points out that when 200 persons are tested with no reactions, sensitizers of the order of 1 in 1,000 would fail to give reactions in 82 per cent of random groups of 200 patients.

Despite these elaborate studies, sensitizations are found to occur. For this reason the "use" part of this test is now employed. It simply means that the product being investigated is used for one or more months on as large a number of persons as possible in the manner in which it is intended to be used. This is time consuming but it must be done to give reliable estimates of the safety and sensitization index of the test material.

A control test with the patch itself is helpful in learning to read the patch reactions. An occluded damp skin area will often have a slightly reddened macerated appearance after a 48 hour time interval. Re-read doubtful skin reactions after a 5 to 30 minute period. Further information may be obtained by observing the tested area for an additional 1 to 10 days. If the reaction is still not clear, repeat it on a new skin site. Delayed reactions may appear up to a week or more later. These may represent a dermal rather than an epidermal response to the test material. The epidermal reactions vary and are reported from a zero reaction to a definite redness or one plus, to redness and follicular involvement or two plus, to redness and papulation and vesiculation or three plus, to bullous formation or a four plus reaction. From 1 to 40 tests may be done at one time. The areas are easily cleaned with benzene, and then alcohol after the readings have been completed.

SUMMARY

THE patch test is simple to perform. It is relatively simple to interpret when properly controlled. Experience in its application and wisdom in its reading is rapidly developed with repeated use of this invaluable detective device.

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Prognosis in Hypertension

Perera (Journal of Chronic Disease, 1:121, April 1955) says that resting blood pressure determinations are much more important than casual readings in evaluating the course of hypertensive vascular disease and in interpreting effects of hypertensive drugs. In one group of 25 patients the average casual blood pressure was 203/121 and the average resting pressure was 146/89. These patients, designated as labile hypertensives, died at the average age of 56, twenty-three years after the known onset of hypertension. The casual pressure in another group of patients averaged 207/123 and the resting pressure 192/117. These were designated as nonlabile hypertensives. The latter group died at an average age of 44, thirteen years after the known onset of elevated pressure.

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Vascular Disease in Ophthalmology*

Not only the mirror of the soul, but also a window for the circulatory system is Dr. Mermod's apt characterization of the eyes. This paper highlights the extraordinary usefulness of ophthalmologic study in detecting vascular disease.

The normal function of the eyes depends on an adequate circulatory system. *Many diseases or abnormalities found in the internal organs can be recognized in the vessels of the eye.* Sometimes they can be found there earlier because of the visibility of the fundal vessels. Thus, White [1] says: "The eyes afford more clues in a cardiac patient than any other part of the body except the neck and the heart itself." The eyes might then be called the windows of the circulation as well as the windows of the soul.

Conditions which stand out prominently as causes of abnormalities in the eyes may be classified roughly into three categories:

1. Infections attacking the blood vessels proper or causing secondary changes in them.
2. Vascular abnormalities preventing properly oxygenated blood from reaching the eyes.
3. Structural changes in the vessel walls resulting in partial or complete obstruction of the blood flow.

Of the infections, those causing emboli are the ones which cause us most concern. The branches of the ophthalmic artery are end-arteries. Thus, the damage caused by such emboli varies with the size of the branch which has been occluded. Subacute bacterial endocarditis may be first diagnosed by partial loss of vision resulting from the embolization of a vessel followed by petechial hemorrhages. Such findings in a young adult should lead to laboratory examinations, especially to blood cultures, to establish a diagnosis.

Other cardiac diseases in which there is a tendency to the formation of emboli are myocardial infarction and auricular fibrillation. Small portions become easily detached from the mural thrombus or that found in the auricular appendage. Because of their small size, they cause no noticeable damage in the general circulation; or only slight tenderness in the splenic or renal region. If an ophthalmic artery is blocked, however, partial or complete loss of vision may result.

Collagen diseases also give rise to embolic phenomena in the eye vessels. Under certain conditions, they act like infections, with variations in temperature, leucocytosis, and increased sedimentation rate. Under other conditions, the same disease appears to be the result of an allergic reaction to bacteria or other endogenous substances. Selye [15] considers them the result of stress conditions in the body. The diffuse collagen diseases "are characterized histologically by a localized or generalized vasculitis, by a swelling of the ground substance of the connective tissue and by increased visibility and thickening of the collagen fibers. Later there may be an infiltration with leucocytes, often with a high percentage of eosinophiles, and finally fibrinoid degeneration and

* Read April 20, 1955 at the Section on Ophthalmology, Annual Meeting of The Medical Society of New Jersey.

necrosis."[2] In a careful review, Hollenhorst and Henderson[3] discuss the diagnostic difficulties in differentiating these diseases, and the fact that their manifestations are so protean that, for example, "disseminated lupus erythematosus may prove ultimately to be the correct diagnosis in a case in which the original diagnosis was rheumatoid arthritis." Periarteritis nodosa, lupus erythematosus, dermatomyositis, temporal or cranial arteritis, thrombo-angiitis obliterans may all have varying degree of inflammatory or toxic reaction in the retinal vessels, with subsequent embolization or hemorrhage. The optic nerve, retina, iris, conjunctiva, ocular muscles, or eye lids may be affected individually or together giving rise to bizarre clinical pictures. Blindness may result from intra-ocular changes, or from disease of the cranial vessels and secondary changes in the brain substance. In rheumatoid arthritis the most frequent ocular changes are found in the sclera and conjunctiva, causing the patients to mention that they suffer from "arthritis of the eyes," a very illuminating misnomer.

THE sensitivity of the central nervous system to hypoexemia or temporary anoxemia are well recognized. The similar sensitivity of the retina is frequently forgotten. Temporary or permanent blindness may be the result of any condition which reduces the amount of oxygenated blood reaching the eye.

In "blacking out," a lessened amount of blood reaches the cerebral centers. With that, there is a temporary loss of light perception. Repeated massive hemorrhages by prolonging this lack of oxygen may result in complete blindness. The rarity of such cases is shown by Haab[4] who states that he did not see any blindness in 60,000 massive hemorrhages which he had traced. However, a number of cases are reported in the literature in great detail in which the authors discuss (but are unable to define exactly) the mechanism causing the visual disturbances. The most frequent sites of the hemorrhages are the gastro-intestinal tract and uterus, though any excessive blood loss may cause this condition. In a recent article by Kline,[6] a case of ruptured ectopic pregnancy is reported. The patient was brought to the hospital after two days of vaginal bleeding with a hemoglobin of 49 per cent. She was given a transfusion and operated upon the next day for ectopic pregnancy. The day following surgery, the patient complained of impaired vision. Energetic treatment with vasodilators resulted in almost normal vision in one eye, but only perception of the hand movement in the other.

Alfano and Roper[5] tell of an elderly man who had almost total loss of vision following a massive gastro-intestinal hemorrhage (hemoglobin at admission was only 3.7 Grams per cent). With general treatment the sight improved slowly to 20/200 in each eye. The edema of the retina disappeared and the hemorrhages absorbed, but marked scarring remained.

Bietti[7] and his collaborators investigated the reaction of the eye to anoxia induced by experimental means such as breathing oxygen-poor mixtures, vasoconstriction, head-seat acceleration and compression of the eye ball. They note that anoxemia affects not only the visual capacity, but also the functions of all the anatomic parts of the eye and may be used diagnostically.

It may be that because of the improved treatment of patients with massive hemorrhages, we shall meet this syndrome more often. Formerly, before the common use of large amounts of blood, most patients who suffered such exsanguinating hemorrhages, died, and their visual ability was not tested. Since it is now the usual practice to carry such patients along on borrowed blood, the damage to the sight may become more noticeable. Any complaint about sight, should therefore be noted and treatment with vasodilators started immediately.

ANOTHER impairment of sight, connected with diminished oxygenation of the retina, is that resulting from severe injuries of the head and chest. Following the injury, the patient may go into shock. When he recovers from the shock, he may complain of inability to see clearly.

Cases like that were first reported in 1910 and have been called "Purtscher's disease,"[8] or angiopathia retinae traumatica. Most of the cases reported suffered blindness in both eyes. It may be that, as a result of the crushing blow, there has been a sudden wide distension of the blood vessels in the whole head and neck and with it more or less extravasation of blood. In other cases, no such direct mechanism can be invoked and it is more likely that there is a reflex vasospasm similar to that causing injury in the kidney in the "crush syndrome."

Wagener[9] states: "It is rather unlikely that the increased cerebrospinal fluid pressure postulated by Purtscher[8] is present in many of these varied injuries. Nor is it likely that primary hemorrhage into the optic nerve or its sheathes account for all the cases of immediate transient loss of vision and later progressive optic atrophy. It would seem more probable that local anoxia is the basic cause of both the retinal and optic nerve lesions."

This lesion may become more frequent in this day of rapid transportation and automobile accidents.

THE ocular changes encountered more often than any mentioned above, are those due to vascular degeneration found in hypertension. Thus, Schroeder[10] notes that "Prolonged arterial hypertension leads to changes in the arterioles throughout the body." He emphasizes that the kidney rendered ischemic by neurogenic vasoconstriction, produces toxic pressor substances which can cause necrotizing lesions in arterioles. Early in the disease when the blood pressure is intermittent, little vascular change is found, but if the episodes increase in severity or length, the amount of pressor substances produce increases and, with it, the likelihood of cerebral hemorrhage or thrombosis.

In neurogenic hypertension, a fluctuation of blood pressure may be present for years before arterial changes are severe enough to result in cerebral hemorrhage or thrombosis.

In generalized arteriosclerosis, the blood pressure rises as the result of lessened elasticity of the vessel wall. The narrowing of the vessels is gradual and retinitis rare. On the other hand, in malignant hypertension, we find a rapidly progressing disease with serous and hemorrhagic extravasations[9] in the retina. This may be accompanied by or preceded by arterial spasm. The clinical story is usually that of relatively sudden appearance of the increased blood pressure in middle age, with little response to sedation. The blood pressure may be lowered, as a rule, with reserpine or other newer drugs in addition to surgery, giving the clinicians better weapons to fight the disease.

The arterioles in malignant hypertension show a hyaline change in the subendothelial layer[11] "which may be accompanied by necrosis of the endothelium converting the whole arteriole into a solid, almost structureless cord." The rapidity of these changes varies with the individual. A patient may be having an apparently well controlled hypertension, with normal chemical and urinary findings, when, suddenly, partial blindness occurs. A complete blocking of one of the arteries has occurred. This does not respond to vasodilators. Spasm, embolization, or complete shutting of the lumen all play a role. In such cases, anticoagulants and vasodilators should be started and used continuously in the hope of preventing further damage.

EYE lesions in diabetes mellitus have long been known. Visual disturbances may be the first symptoms of the disease. As far back as 1936, Kimmelstiel and Wilson[12] showed a "conspicuous relationship between a syndrome of diabetes, nephrotic edema, gross albuminuria and hypertension and a peculiar type of intercapillary sclerosis of the glomeruli." The relationship of retinal changes to kidney changes has been noted. Kimmelstiel and Porter[13] state "With the exception of chronic glomerulo-nephritis, it can be stated that diabetes occurs in almost all cases of intercapillary glomerulosclerosis, and retinopathy in 86 per cent of cases with the advanced lesion."

Also "It precedes the renal changes and is more closely related to the diabetes than to the vascular or glomerular disease."

Friedenwald [14] studied the retinal blood vessels with special staining technics, and found that, in addition to the sclerotic changes in the arteries, there are many capillary aneurysms, mostly in the central retinal region. These small punctate aneurysms are surrounded, in the more advanced cases, by masses of exudates and by frank hemorrhages. He feels that these capillary aneurysms are characteristic of diabetes, and distinguish it "from the retinopathy of arteriosclerosis or of malignant hypertension."

This brief, and necessarily incomplete resumé of the relationship of the circulatory system to the eye, emphasizes the need of close cooperation between the ophthalmologist and internist for the greater good of the patient.

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Adrenal Function and Cortisone Therapy

In the Archives of Internal Medicine (95:411, April 1955), E. W. Fredell and his associates report on a study of 19 patients who had received prolonged cortisone therapy. It is evident that the adrenal cortex was suppressed but remained responsive to stimulation with corticotropin. Responsiveness may be inversely proportional to the length of therapy but this observation was not conclusively demonstrated. It is reassuring to have evidence that cortisone-induced atrophy of the adrenal cortex is reversible but it is nevertheless true that patients who have recently received cortisone may require additional hormone for maintenance through any period of stress.

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Treponemal Antigens and the Immobilization Test*

Dr. Dickman is a nationally known serologist. He is a member of the Advisory Council on Serology, U.S. Public Health Service. He speaks here of the Immobilization Test which has a useful place in our diagnostic tool kit when carefully done in selected cases. What cases? Read on, and find out.

Almost every practitioner has been faced with the disturbing situation of a reactive serologic test for syphilis with no clinical history, symptoms, or exposure to the disease.

With our premarital and prenatal laws, millions of serologic tests are performed annually on presumably healthy individuals. We are alert to the problems involved if a positive serologic test is reported. The incidence of biologic false-positive reactions during pregnancy is of particular concern. Wilkinson states that in 244 patients found sero-positive on routine testing during pregnancy, 27.5 per cent gave presumed non-specific reactions. In a comparative study of 572 problem sera which were reactive with standard serologic tests, the Kahn gave 17 per cent non-specific reactions, the Wassermann with lipoidal antigen 13 per cent, and the Wassermann with cardiolipin antigen 23 per cent.

Nelson in 1948 described a technic for maintaining virulent organisms of the Nichols strain of Treponema pallidum alive and motile *in vitro* long enough for immunologic studies. Since the description of a procedure for its practical application, the Treponema Pallidum Immobilization Test (TPI) has become generally accepted as a specific test of past or present syphilis in the absence of other treponematoses of the yaws-bejel-pinta group. It has become the reference test for the evaluation of results with the standard serologic tests for syphilis. It is the ultimate means for the identification of biologic false-positive reactors.

Biologic false-positive or non-specific reactions in the standard serologic tests for syphilis have been suspected for many years and recognized for a few. The increasing evidence of positive reactions occurring in conditions other than syphilis has stimulated the search for a specific treponemal antigen. Until the recent development of the Treponema Pallidum Immobilization Test, there was little that could be done in the laboratory to differentiate accurately between non-specific and specific reactions. Various other tests which were introduced from time to time were found wanting.

Estimates of biologic false-positive or non-specific reactions cover a wide range, from 3.35 per cent to more than 40 per cent of positives by standard serologic tests. This wide varia-

*Based on a more detailed paper read before the N. J. Health Department's Serologic Conference, October 26, 1955.

tion in figures is influenced by the group evaluated, the serologic tests employed, and the definition of positivity.

There is currently considerable discussion on the future position of the standard serologic tests for syphilis. Some, such as Dr. Joseph Earle Moore, consider such tests on the way out, to be replaced by newer technics using treponemal antigens. The TPI test has been in use for about eight years. Other technics employing treponemal antigens have been recently developed and are currently undergoing evaluation. In the near future the physician will be able to weigh the relative merits of various serologic tests, employing in addition to the usual non-specific antigens, antigens derived from pathogenic and possibly non-pathogenic strains of treponemes.

Standard serologic tests for syphilis (such as the flocculation tests and complement fixation tests) although dependent upon antigens derived from materials other than the causative organism, have attained an important position in the clinical laboratory, and considered from all aspects possess a very high degree of accuracy and reliability as laboratory procedures. The *absolute* incidence of non-specific reactions has been estimated as only about one in 500 to 700.

In addition to the TPI test, there have been developed the Immune Adherence Test (TPIA), and Agglutination Tests (TPA) which involve the use of suspensions of killed organisms of the pathogenic Nichols strain. A Treponemal Complement Fixation Test (TPCF) uses an antigen made from a fraction of the same organism.

The TPI test involves the use of living virulent organisms. It is a test for the detection of *specific* antibodies against the etiologic agent of syphilis. Up to the present time, the immobilizing antibody has not been demonstrated with certainty in conditions other than in the treponematoses of the syphilis-yaws-pinta-bejel group. In a recent tabulation of TPI tests on 1868 patients presumed to be non-syphilitic only 4 gave positive reactions (0.2 per cent) and 2 gave doubtful reactions (0.1 per cent) and in none of these could syphilis be absolutely excluded.

The treponeme is a mosaic of antigens. While some of the fractions are found in the spirochete exclusively, others are not. There is some question as to whether the newer treponemal tests depend on the presence of the same specific antibodies.

Although non-pathogenic Reiter, Nichols, and Kazan strains have been cultured, there is no evidence that this has been the case with an organism proved to be truly pathogenic. The virulent Nichols strain of Treponema pallidum was isolated in 1912 and maintained since that time by animal passage. The organism is a true pathogen. Recently, after more than forty years of animal passage, it produced typical primary lesions in human volunteers. While immobilizing antibodies have been regularly demonstrated as a result of infection of rabbits with virulent spirochetes of the Treponema group, they have not been demonstrated in animals experimentally infected with Leptospira or Borrelia or in animals artificially immunized with non-virulent cultivatable spirochetes such as the Reiter, Kazan, or S-26 strains.

Eagle and Germuth studied the serologic relationships among five cultivated strains of Treponema pallidum, the Noguchi, Kroo, cultured Nichols, Reiter, and Kazan, together with two strains of mouth spirochetes. They observed varying degrees of cross reaction between the Reiter and Kazan strains and the oral spirochetes. All five treponemal strains were found to differ materially in their morphology and antigenic properties from Treponema pallidum.

With the appreciation of the tremendous advance in syphilis serology resulting from the development of the TPI test, there has been a tendency to highlight its importance and to overlook its limitations. Wilkinson states that in early (primary and secondary) syphilis, the test offers no advantages over existing diagnostic methods. In late (symptomatic) syphilis, where the standard serologic tests are positive, the TPI has only confirmatory value. But in the diagnosis of suspected latent syphilis, it is a most valuable confirmatory test. In patients who present signs and symptoms which may be attributable to late syphilis but in whom the

standard serologic tests for syphilis are negative, a positive TPI is strong evidence of the disease.

Vaisman, Hamelin, and Vaisman found the TPI *invariably negative* in sero-negative primary syphilis before treatment. The reaction became positive later in most cases. It persisted up to 18 months in spite of negative serologic test for syphilis and treatment. In sero-positive primary and secondary cases, the TPI became positive later than was the case with other reactions and remained so longer. It was positive in all cases of congenital syphilis, asymptomatic latent syphilis, and other advanced stages of the disease. The titers of immobilizing antibody have usually been found high. In latent and late symptomatic syphilis, the antibody may persist for life in spite of treatment.

Today, the TPI test using the pathogenic Nichols strain of living Treponema pallidum appears to be the test of choice as a reference procedure. The condition of a specimen submitted for a TPI test is of vital importance. The specimen must be sterile. Contaminating bacteria may be destructive of complement and treponemacidal. Chylous specimens should be avoided, since they may make the test harder to interpret. Specimens of blood should be collected in sterile tubes provided with a paraffined cork. Rubber stoppers and other types of closures have sometimes been found to contain treponemacidal substances. If a vacuum collecting tube is used, the rubber stopper should be removed after filling the tube and replaced with a paraffined cork. If delay of delivery of the specimen is anticipated, sterile serum should be submitted. Antibiotics should not be administered by mouth for a week, or by injection for at least a month prior to collecting the specimen. The presence of penicillin if known, can be generally counteracted during performance of the test with penicillinase.

SUMMARY

1. All physicians face the problem of reactive serologic tests for syphilis in persons without history or clinical evidence of syphilis. This is the problem of the possibility of biologic false positives.

2. Standard serologic tests for syphilis utilize non-specific antigens. Would an antigen derived from syphilis organisms (Treponema) give more specific results in determining the presence of syphilitic antibodies?

3. The Treponema Pallidum Immobilization Test (TPI) uses living pathogenic organisms. This gives specific reactions in the presence of syphilitic antibodies, provided the patient has no diseases of the yaws-bejel-pinta group.

4. The test involves elaborate and costly procedures which will restrict it to limited performance in specialized laboratories.

5. The test should be used as a diagnostic criterion where there is doubt (after thorough clinical and serologic investigation) as to the validity of a reactive laboratory finding.

6. Experience is being gathered in the use of Treponemal antigens in procedures less troublesome than the TPI Test. It is hoped that these procedures will prove to be equally as sensitive and specific.

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Prednisolone-Buffered* Salicylates

In the Treatment of Non-articular Rheumatism†

"No other therapy for non-articular rheumatism has produced such rapid subsidence of symptoms." So writes Dr. Tillis from the Newark Presbyterian Hospital Arthritis Clinic, describing the use of a prednisolone-buffered salicylate regimen in bursitis, tenosynovitis, and fibrositis.

There is a group of essentially inflammatory non-articular disorders where treatment remains generally unsatisfactory. This includes bursitis, fibromyositis, and tenosynovitis, and many other ailments commonly encountered in office practice which defy satisfactory diagnosis, with a chief presenting symptom of somatic pain. This pain is often, but not always associated with a joint. It may be of sudden onset, recurring, or chronic; it may respond only indifferently to conservative treatment.

The adrenal glucocorticoids cortisone and hydrocortisone have become well established in therapy as their anti-inflammatory effect has been demonstrated. First used in treating rheumatoid arthritis,[1] their value has now been shown in a wide range of inflammatory conditions including skin and ocular disorders,[2] rheumatic fever,[3] and a number of allergic diseases.[4]

No agent has been used more widely than salicylate for its analgesic and anti-inflammatory effects in both articular and non-articular disorders. Although critical studies[5] have shown no significant difference between cortisone and salicylate in the long-range treatment of rheumatoid arthritis, there is general agreement that glucocorticoid exerts its anti-inflammatory effect much more rapidly than salicylate.

Until recently, the irritant action of salicylate on the stomach mucosa frequently prevented its full use. The development of a properly buffered salicylate[7] has satisfactorily eliminated this disturbing side effect.

*The prednisolone used in this study was the Pfizer tradenamed brand designated Sterane®. The Bufferin® was aspirin buffered with magnesium carbonate and aluminum glycinate. These were kindly and generously supplied by the Medical Departments of the companies—the Pfizer Laboratories of Brooklyn (Sterane) and Bristol-Myers Products of New York City (Bufferin).

†This work is from the Arthritis Clinic of the Newark (N.J.) Presbyterian Hospital.

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In the common inflammatory non-articular disorders, glucocorticoid [5] therapy might be expected to have some beneficial effect; yet one is properly reluctant to treat these more casual disorders with agents capable of exerting powerful and undesirable systemic effects.

The need for an improved anti-inflammatory agent in these conditions might be met by a glucocorticoid in which the anti-inflammatory effect is enhanced while mineralocorticoid and other undesirable effects are minimized. Such a compound is prednisolone,* an analogue of hydrocortisone which differs from it chemically in bearing a double bond at carbon 1. As an anti-inflammatory agent, prednisolone has four times the pharmacologic effect of hydrocortisone, weight for weight; yet in therapeutic doses its influence on electrolyte balance is negligible.[8] Sodium is not retained, nor is potassium lost. It has been used successfully in rheumatoid arthritis [9] and ocular disorders.[8]

The idea that short-term therapy with small doses of prednisolone* and salicylate might benefit non-articular rheumatism provides the basis for this study; in view of the known gastro-intestinal disturbances resulting both from prednisolone* and from salicylate, it was decided to use buffered salicylate (Bufferin®).

MATERIALS AND METHODS

PREDNISOLONE* and buffered salicylate were used to treat 80 patients suffering from non-articular rheumatism. The conditions for which it was prescribed were varied, but shared in common a painful inflammation of connective tissue. More than a third of the patients had bursitis of various joints. Other cases were diagnosed as fibromyositis and tenosynovitis, while still other inflammations were induced by physical strain, surgical trauma, or unknown agents.

When first seen for treatment, the patients had been suffering from non-articular rheumatic disorder usually for several weeks, but much longer in several instances. Most of these patients had already been treated unsuccessfully with other agents, including salicylates, codeine, heat, and in several instances other glucocorticoids, before being given prednisolone.* In this study a standard regimen of therapy was adhered to with few exceptions. This consisted of orally administered prednisolone* in divided daily doses: 15 milligrams on the first day, reduced by 2.5 milligram decrements each day to a daily dose of 5 milligrams. This was continued as long as treatment was necessary. Generally, prednisolone* was discontinued within a week, although in several instances therapy was maintained longer than a month.

During the period of prednisolone* therapy, buffered salicylate was administered in doses of 10 grains every four hours. It was felt that gradual reduction of the prednisolone* and maintenance of constant doses of aspirin might prolong the effectiveness of the therapy until the symptoms were completely alleviated.

RESULTS

THE results of prednisolone*-buffered salicylate therapy in these 80 patients are presented in the accompanying table. The effect of the treatment was rated *excellent* when there was complete and prompt remission of symptoms, *fair* when symptoms were only partly alleviated, and *poor* when there was little or no response. Some of the disorders would be expected to be self-limited. But relief without

PREDNISOLONE*-BUFFERED SALICYLATE
RESULTS OF TREATMENT

Number of Patients	Diagnosis	Excellent Results	Fair Results	Poor Results
30	Bursitis	28	0	2
8	Fibrositis	6	2	0
4	Tenosynovitis	4	0	0
8	"Back strain"	4	0	4
30	Myositis, neuritis and all others	18	2	10
80	Total cases	60	4	16
100%	Percentages	75%	5%	20%

8. King, J. H. and Weimer, J. R.: Archives of Ophthalmology, 54:46 (1955) *and* Bunim, J. J. *et al.*: Annals of the New York Academy of Science, 61:358 (1955)
9. Spies, T. D. *et al.*: GP, 12:73 (1955).

exception was obtained promptly, within one or two days after instituting prednisolone,* or was not obtained at all during the entire course of therapy. This was true regardless of the previous duration of the disorder, which in 64 of these patients had persisted more than a week. Thus there is excellent correspondence between the beginning of therapy and the beginning of improvement. Such prompt response is in agreement with the generally observed fact that the effects of steroid therapy are noticeable within a day or so. Further, it is my experience that in a practice devoted exclusively to rheumatic diseases, *no other therapy of non-articular rheumatism has achieved the rapid subsidence of symptoms described here.*

FINALLY, the pattern of recurrences suggests that improvement was causally related to the prednisolone* therapy: There were eight patients in the group in whom diminished doses of prednisolone were followed by a recurrence of symptoms. In each of these, the initial dose of 15 milligrams a day was repeated, and resulted in each case in prompt disappearance of symptoms. In no case did symptoms appear again, even when the drug was eventually withdrawn.

Results with prednisolone*-buffered salicylate were exceptionally good in bursitis. All but 2 of 30 patients were completely relieved of pain; similar relief was obtained in 4 patients with tenosynovitis; and in 6 of 8 with fibrositis. Of the entire group of 80 patients, 64 (80 per cent) were improved with this therapy, 60 of these receiving prompt and lasting relief of symptoms.

In analyzing the 16 therapeutic failures, two factors seem significant: failure is likely when the patient shows neurotic symptoms and the complaint is largely psychogenic. Four patients who experienced no relief and one who was only questionably benefited were known to have neurotic difficulties. Failure is also likely in severe sudden tearing or shearing injuries to connective tissue. This is exemplified by four patients who suffered acute "back strain" associated with lifting heavy objects. In each case, the trauma was an actual tearing of connective tissue. The drug did not help these four patients. One of these was found later to have a herniated intervertebral disc. This was repaired surgically.

Examination of the table shows an unusual distribution of results in this group of patients. Almost without exception, the use of prednisolone* and buffered salicylate was followed by complete symptomatic relief or by total therapeutic failure. Only four patients could be classified as "partly benefited." Such an extreme pattern of effectiveness is uncommon, and its significance here is obscure.

During the clinical trial of this combination therapy, undesirable side effects were remarkably infrequent. Four patients reported mild gastric distress, and one, a registered nurse, correlated urinary frequency with therapy. No changes involving electrolyte balance or secondary sex characters were observed during this study; for the most part none were expected during this short-term therapy. The average duration (prednisolone* phase) was six days. However, eight patients received daily doses of 5 to 15 milligrams of prednisolone* for periods exceeding four weeks. These patients remained free of any undesirable reactions.

SUMMARY AND CONCLUSIONS

WITH the availability of glucocorticoids which can suppress inflammation without unduly disturbing homeostatic mechanisms, it is rational to use them in inflammatory disorders otherwise refractory to treatment. In contrast to the long-term maintenance therapy of rheumatoid arthritis with glucocorticoids, the present study has explored their value, together with buffered salicylate, in treating non-articular rheumatism of several types, with the notion that relatively small doses of steroid over short intervals should be effective in relieving painful inflammations of connective tissue.

Short-term therapy with small amounts of prednisolone* and buffered salicylate was tried here in the treatment of 80 patients with bur-

sitis and other non-articular rheumatisms. Complete and lasting relief from pain was achieved promptly in 75 per cent of these patients, where such prompt improvement could not be expected in any case under ordinary therapy. No serious side effects were observed in spite of careful watch for electrolyte imbalance and gastric intolerance.

It can be justifiably concluded from this study that small doses of prednisolone* and buffered salicylate relieve the pain of various non-articular rheumatisms and hasten symptomatic recovery.

The absence of undesirable reactions to prednisolone* and buffered salicylate here suggests that it may be feasible to use this therapy effectively for the short-term treatment of common disorders that are not so grave as to be incapacitating or life-threatening. Caution must be exercised, however, until further studies have established the safety of this combination therapy.

31 Lincoln Park

Cobalt and the Thyroid

It has been suggested that a cobalt salt could produce reversible hypothyroidism, particularly in infants with sickle cell anemia.[1] Other authors [2] deny the toxicity of cobalt with reference to the thyroid. Klinck,[3] reviews the findings of 10 cases of thyroid hyperplasia in young children. Five had received cobaltous chloride and ferrous sulfate. The microscopic picture in both groups was similar. Klinck stresses the importance of using caution in ascribing the changes noted to any one factor. The histologic picture of hyperplasia may result from many causes. He concludes that goitrogenic activity of cobalt cannot be established. Holly [4] conducted a controlled investigation on 227 pregnant women, plus their offspring, and also studied the effect of cobalt in animals. There was no evidence of toxicity in the 78 women who received cobalt alone or with iron. All children resulting from these pregnancies were normal. No thyroid enlargement was encountered. In the animal investigation, no demonstrable histologic change was noted. The significant effect of cobalt plus iron in pregnancy is the maintenance of normal hematologic values in nearly all the patients.

Jaimet and Thode,[5] conducted extensive thyroid function studies on 17 children receiving Roncovite® in liquid form. No thyroid enlargement was seen in any case, nor did clinical hypothyroidism develop. The authors conclude that cobalt in amounts up to 6 mg. per kilogram daily for ten weeks does not affect any phase of thyroid function as measured by the radioactive iodine tests, and has no goitrogenic action. Scott and Reilly,[6] investigated the effect of cobalt administration on various functions of the thyroid in rats. The usual hematopoietic action was noted, and the incidental observation was made that growth of a transmissible fibrosarcoma was inhibited. There was no inhibition of I-131 uptake, thyroxin synthesis, hormone release or circulating hormone levels. The authors conclude that the addition of cobaltous chloride to the drinking water of rats in 60 mg. per kilogram daily dosage had no appreciable effect on iodine metabolism. Similar results were obtained with an iron-cobalt mixture.

1. Kriss, J. P., Carnes, W. H., and Gross, R. T.: J.A.M.A. 157:117 (Jan. 8) 1955.
2. Editorials and Comments: J.A.M.A. 158:1371 (Aug. 13) 1955.
3. Klinck, G. H.: J.A.M.A. 158:1347 (Aug 13) 1955.
4. Holly, R. G.: J.A.M.A. 158:1349 (Aug. 13) 1955.
5. Jaimet, C. H. and Thode, H. G.: J.A.M.A. 158:1353 (Aug. 13) 1955.
6. Scott, K. G. and Reilly, W. A.: J.A.M.A. 158:1355 (Aug. 13) 1955.

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Poliomyelitis, Pregnancy and Pulmonary Emboli†

Never before has a death from pulmonary embolus been reported in a pregnant woman with poliomyelitis. In this compact monograph, this unique complication is explored.

A recent case of pulmonary embolism in a woman, six months pregnant, convalescing from acute anterior poliomyelitis prompted a review of the literature. Not a single report was found of pulmonary emboli in pregnant poliomyelitis patients, although 604 cases of poliomyelitis during pregnancy[1] are cited. This would seem to justify reporting the following case:

A thirty-year old woman was admitted to the Camden Municipal Hospital on August 13, 1954.

Her last menstrual period began on March 3, 1954. She was well throughout the pregnancy until August 7, 1954, when she felt tired and sneezed excessively for one day. She had no fever or sore throat, and felt better for two days; but on August 10 her malaise returned. On August 12 she could not sit up unassisted, nor move her right leg. She had no pain, difficulty in swallowing, nor constipation.

On admission this moderately obese woman's temperature was 98.8, her pulse was 126 and her respiration rate was 24. Neck and back were stiff; but she was in no distress. Eyes, ears, nose, throat, chest, and heart were normal. The fetal heart was heard in the midline.

Tendon reflexes were normal in the arms and in the left leg, but were diminished in the right leg. Superficial abdominal reflexes were absent. She felt pain on flexion of the thigh. Muscles in the right leg could be contracted, but were too weak to move the leg against gravity.

Spinal fluid contained 307 white blood cells per cubic millimeter. Of these, 12 per cent were neutrophiles, and 88 per cent were lymphocytes. Protein was 75 milligrams per cent. Glucose was 50 milligrams per cent. Blood contained 14 Grams per cent of hemoglobin. Of the 10,600 white blood cells per cubic millimeter, 24 per cent were lymphocytes, and 75 per cent were neutrophiles. Blood type was AB, Rh negative. Mazzini was negative. Type 1 poliomyelitis virus was isolated from her stool in tissue culture of HeLa cells. On admission the serum poliomyelitis neutralizing antibody titers were 1 to 75, less than 1 to 10, and 1 to 100 respectively against poliomyelitis types I, II, and III. Two weeks later the respective titers were unchanged. Weekly urinalysis showed no sugar or albumin and contained 2 or 3 white blood cells per high power field.

Her temperature rose to 102 on the second hospital day but was normal thereafter. She developed increasing weakness of her right leg, and minimal weakness of the left leg. Physical therapy report was: "The first evaluation, twelve days after admission, showed obvious severe weakness of the right lower extremity and poor muscle power in the left hip and knee with good power in the foot

†Aided by a grant from the National Foundation for Infantile Paralysis. This work comes from the South Jersey Research Foundation and the Camden Municipal Hospital.

1. Bowers, V. N. and Danforth, D. N.: American Journal of Obstetrics and Gynecology. 65:34 (January 1953)

except for the anterior tibial. There was severe spasm of the hamstrings on the left, and moderate spasm on the right. The lumbar spine was moderately tight. The left upper extremity was apparently normal, but there was minimal weakness of the right shoulder and elbow groups. The trunk muscle power was present, but it was not evaluated due to pain and spasm. Slight weakness of the right sternocleidomastoid was present."

Treatment consisted of prone packs, and passive motion twice daily. Her shoes were fastened to a board and were to be used as tolerated to prevent contractures. As the pain lessened, passive motion of the legs and arms was increased and continued until she had straight leg raising to ninety degrees, and full range of motion of the arms. Three weeks after onset, combined active and passive motion was started in addition to the earlier routine. Active resistive exercises for the upper extremities were begun.

On October 7, 1954, forty-two days after admission: "Most hip muscle groups on the right were poor, the peroneals were fair, the toe extensors good, the hallux flexors were zero. The left extremity showed improvement in power, although the hip groups, the quadriceps, and the anterior tibial were still poor, the calf group seemed normal, and the peroneals and the flexors and extensors of the toes were good. The only tightness remaining was the calf group on the left and the left hamstrings. The back was relaxed. Sitting balance was good, and the patient showed good trunk power."

On September 27 vaginal discharge was noted. After a few days this subsided. By October 8, 1954, she was first up in a wheelchair.

On October 24 she complained of shortness of breath. Vital signs were stable: her pulse was 130, blood pressure was 120/70, and she had a normal sinus rhythm. Blood count showed 8,350 white blood cells per cubic millimeter with a normal differential.

By the evening of October 25, the patient appeared frightened. Pulse was 130. Physical examination was normal. At nine in the evening she cried out with chest pain. Pulse was then 150. An oxygen tent was ordered. The chest pain was along the diaphragmatic attachment. Vital capacity had decreased from 1700 to 1000 cubic centimeters. Liver edge was 3 centimeters below the costal margin; respirations were 40 per minute. Electrocardiogram showed a slight S_1 and inverted T_3 which was considered normal by the cardiac consultant who did not feel a pulmonary embolus was present. Meperidine* promptly relieved the apprehension and the pain. The patient then fell asleep. At midnight Digalen® was given, and the pulse hovered around 110 for the rest of the night. She vomited once.

At 7 a. m., October 26, 1954, she cried out again with chest pain, became cyanotic and partly unresponsive. Blood pressure and pulse were not perceptible. Fetal heart was not thereafter audible. White blood count was 32,950 cells per cubic millimeter. Of these, 59 per cent were segmented neutrophiles, 17 per cent band forms, and 22 per cent lymphocytes. The carbon dioxide combining power was 38 volumes per cent. Urine contained many hyaline casts, 4 white blood cells per high power field, four plus sugar, no acetone, and 12 milligrams of protein per hundred cubic centimeters. Electrocardiogram showed "development of right bundle branch block plus deep S_1, inverted T_3. These are highly suggestive of pulmonary embolization. Q_3 has not developed." Electrocardiographic impression was "myocardial damage with probable pulmonary embolus (cor pulmonale)."

Her shock was treated with plasma, and norepinephrine with a rise in blood pressure to 70/70. Additional digitoxin and meperidine* were given. At 1:30 p. m. she cried out with chest pain and expired. A stillborn premature girl weighing 4 pounds was delivered by postmortem cesarean section ten minutes later.

Here are the significant autopsy findings:

The heart weighed 390 Grams. The right heart was considerably dilated. The endocardium and valve leaflets were entirely normal. Coronary arteries seemed to be without pathology.

The right lung weighed 530 Grams, and the left 380 Grams. Both lower lobes were somewhat bluish-purple in color with petechial hemorrhage beneath the pleural surface. Large antemortem clots filled both pulmonary arteries. These emboli extended to the larger branches of all lobes. On sectioning the lungs, the dependent parts showed marked congestion. Even the smaller branches of the pulmonary artery contained blood clots. Section of the clot from the pulmonary artery indicated that it was antemortem.

The liver weighed 2260 Grams. Grossly and microscopically the liver and spleen showed severe acute passive congestion.

There was no gross pathology of the adrenals, but microscopically there was passive congestion with slight hyperplasia. The pancreas was soft and showed acute passive congestion and extensive postmortem degeneration. The autopsy diagnosis was "extensive, bilateral pulmonary emboli."

Ever since Schell[2] reported poliomyelitis and pregnancy occurring together in 1909, additional cases have been listed. Aycock[3] summarized 56 cases with 3 deaths in 1941. Weaver and Steiner[4] were able to find 75 cases with two deaths by 1943. Aycock's[5] total reached 236 by 1946. Gifford and Hullinghorst[6] added

*Tradenamed as Demerol®.

2. Schell, J. T.: New York Medical Journal, 83:657 (March 31) 1906

3. Aycock, W. L.: New England Journal of Medicine, 225:405 (September 11) 1941

4. Weaver, H. M. and Steiner, G.: American Journal of Obstetrics and Gynecology, 47:495 (April 1944)

5. Aycock, W. L.: New England Journal of Medicine, 235:160 (Aug. 1) 1946

6. Gifford, H. and Hullinghorst, R.: American Journal of Obstetrics and Gynecology, 55:1030 (June 1948)

170 cases with 19 per cent mortality in 1948. Horn [7] found 552 cases by 1951 with 13 per cent mortality, and Bowers and Danforth [1] in 1953 brought the total to 604 with a 10 per cent mortality.

Most of the deaths were due to bulbar involvement and its complication of pneumonia. Thus poliomyelitis during pregnancy is being reported with increasing frequency.

At the Camden Municipal Hospital during the 1954 season, of 25 female patients over 15 years of age with poliomyelitis, 8 were pregnant. This is 32 per cent. This ratio is comparable to that of Baker and Baker [8] who summarized several reports to find that 25 per cent of the female poliomyelitis patients in this age group were pregnant.

This proportion should be compared with the overall incidence of pregnancy in women of child-bearing age. As computed by Aycock,[5] the incidence ranged from 4 per cent in the age bracket of 15 to 19 to 11 per cent in the 20 to 24 age group, with other ages less than thirty-nine being intermediate between those figures. The statistics of the United Nations [9] for the United States are comparable. As estimated for 1945, they show that 13 per cent of the women from 20 to 29 are pregnant per year, 11 per cent of those from age 15 to 39, and 7 per cent of the women from 10 to 55 are pregnant each year. It appears that two to three times more pregnant women contract paralytic poliomyelitis than might be expected from the statistical norms.

Baker and Baker [8] felt that a *postpartum* pulmonary embolus caused death in one of their poliomyelitis patients 5 days postpartum, but no autopsy was done. Since pulmonary embolism is a well known *postpartum* complication, this case will not be discussed further. *Antepartum* pulmonary emboli have been sporadically reported, but not in patients with poliomyelitis. In the Cooper Hospital there is no record of an antipartum embolic complication. During the past 10 years 31,612 women were delivered.

A high incidence of pulmonary emboli might be expected in poliomyelitis patients requiring an iron lung. Yet no cases have been reported.[‡] The opportunities for physical therapy are minimized by the confining quarters. Many such patients cannot move their extremities at all, and stasis is inevitable. Since stasis is a cause of phlebothrombosis,[10] the rarity of this complication in respirator cases and in poliomyelitis in general is not easily explained. It may be a result of the youth of these patients, of their lack of arteriosclerosis, of the fact that poliomyelitis virus does not attack blood vessels, and of the active physical therapy commonly employed in poliomyelitis patients.

Factors commonly associated with emboli are stasis, injury to the endothelium, phlebitis, and a disturbed clotting mechanism. A careful review of this patient's history, treatment, and postmortem examination does not reveal anything unusual to account for the embolic phenomena. Factors conducive to stasis were present, but are common to many poliomyelitis patients. Among these are paralysis, pregnancy, and the bed rest. The last should help to improve the stasis caused by pregnancy. Pressure on the leg veins from the seat edge of a wheel chair is mentioned by Homans [11] as a cause of thrombosis. This patient did use a wheel chair for short periods, but in this respect was not different from other patients with equal paralysis. There may have been injury to blood vessels (Quick [12]) while sitting on the thighs, while getting into the wheel chair, or by the manipulations of passive and active motion, but if so, these were not evident clinically.

Blood clots which become pulmonary emboli are usually asymptomatic at their site of

‡See addendum.

7. Horn, Paula: Annals of Western Medicine and Surgery, 5:93 (February 1951)

8. Baker, Milton and Baker, Irene: Minnesota Medicine, 30:729 (July 1947)

9. United Nations: *Demographic Year Book for* 1948. Lake Success, N. Y.

10. Mims, G.: Journal of the American Medical Association, 151:433 (Feb. 7) 1953

11. Homans, Peter: New England Journal of Medicine, 250:148 (Jan. 28) 1954

12. Quick, A. J.: Surgery, Gynecology and Obstetrics, 91:296 (September 1950)

origin[13] and this was true in the patient reported here. Repeated and massive pulmonary emboli were demonstrated, but there was no assurance even at autopsy whether they came from the great vessels of the leg, or from the pelvis or its contents. The one lesson from this case is that *pulmonary emboli can and do occur in poliomyelitis* patients, and one should be alert to this possibility. They may occur much more commonly than has been reported or observed. Certainly one would not expect them all to be fatal, and a high index of suspicion (clinically and at the postmortem examination) might show that this complication is not rare.

On the other hand, every pain in the chest in a respirator patient is not a pulmonary embolus as demonstrated in two patients shortly after the death reported here. These two patients both had pleurodynia due to Coxsackie B. virus, confirmed by virus isolation and serologic examination.

SUMMARY

1. A case of poliomyelitis, complicated by pregnancy, terminating in death due to pulmonary emboli is reported.

2. The incidence of pregnancy complicating poliomyelitis and the factors conducive to thrombosis are discussed.

ADDENDUM

Since this paper was submitted an article appeared by J. K. Mack in the September, 1955 issue of the Illinois Medical Journal (108:185), in which are described two patients with poliomyelitis who died of pulmonary embolism. Neither was a pregnant women, but one was a respirator patient.

13. Allen, A. W.: Surgery, Gynecology and Obstetrics, 96:107 (Jan. 1953)

978 Park Ave. (Dr. Lathrop)

Are Cosmic Rays Harmful?

Apprehension about crews in high-flying aircraft exposed to radiation in the stratosphere is being eliminated by research projects being conducted in the Aero Medical Field Laboratory at Holloman Air Development Center, New Mexico.

Serious questions had arisen about these cosmic rays according to a report by Major David G. Simons, Chief of the Space Biology Branch. It was feared that penetration of these particles into the body of a traveler in the stratosphere might cause formation of cataracts, damage the skin or permanently destroy nerve cells.

To prove whether these hazards existed, it was decided to use plastic balloons. They could maintain altitudes higher than 90,000 feet for long enough to expose experimental subjects to primary cosmic radiation.

These balloons were used to expose living animals to radiation during a series of flights at Sault Sainte Marie. This project dispelled some of the fears of cosmic radiation. Some of the animals sent aloft were exposed to cosmic particles above 90,000 feet for as long as 35 hours.

Monkeys were exposed to cosmic radiation and their performances were observed. The monkeys performed normally after their two flights. After watching the exposed animals for six months following the experiments, scientists tentatively concluded that cosmic particles may have been overestimated as hazards to the nerve system and that a traveler in the stratosphere should be able to perform duties in a normal manner with no serious after-effects.

It had been feared also that cosmic radiation might cause cataracts. After being exposed to radiation, no cataracts were observed in the eyes of the mice. Also none of the specimens lost hair or suffered permanent injuries from exposure to primary cosmic radiation.

None of the experiments evaluating physical and mental functions showed adverse conditions as a result of being exposed to cosmic rays.

Historical Article • • •

HENRY A. DAVIDSON, M.D.
Cedar Grove

His Name Was Mudd

This is the 91st anniversary of a mad act that changed the course of history, and made a still-felt impact on the development of one area of our Republic. A fellow-physician of ours, (his name was Mudd) was entangled in this web. Whether the doctor was an active conspirator or an innocent victim of the nation's fury, we leave to you to decide.

A KNOCK on the door woke Dr. Mudd at 4 o'clock that Saturday morning. He lit a candle, walked downstairs, opened the door, peered on to the lawn. An unkempt young man said that Tyler, his friend, had hurt his leg and was in torment. Dr. Mudd did not want to go to work at that hour on Holy Saturday. But he could not let a fellow creature writhe in pain when he had the power to relieve it.

He stepped out and held the candle high to look at his patient. He saw a young-looking man with an old man's beard, sitting uncomfortably astride a horse. Dr. Mudd and the friend (who said his own name was Tyson) helped the patient off the horse. Then Dr. Mudd went ahead, pushed open his door, invited the strangers in.

And in doing so, he opened the door to the man and the event that were to be the fame and ruin of his life.

Dr. Mudd put Tyler on a couch, tried to pull off the left boot. This provoked such agony that the doctor had to slit the boot to free the leg. He pulled it off gently and felt a broken left fibula. Dr. Mudd carelessly tossed the boot into a corner of the room. That boot was to come within a hair's breadth of hanging him.

By now it was 5 a.m. Tyson and Tyler fell into a fitful sleep in the Mudd guest room. The doctor had another 3 hours of sleep, and then started on his rounds. Later that morning he went to Bryantown to get the mail and the news. There was little mail. But there was much news.

Last night the President had been shot. He was now dying in a little boarding house on Tenth Street. The murderer was John Wilkes Booth, an actor well-known to the staff at Ford's theatre. Bryantown was full of rumors. It was said that Jefferson Davis had personally headed the conspiracy, or that Robert E. Lee was piloting an uprising against the now leaderless republic. It was said that there were 100 in the plot, or 1,000 or 10,000. But what interested Bryantown most was that there was good reason to believe that Booth and Herold, one of the conspirators, were somewhere in Charles County.

Booth had crossed the Anacostia River bridge at 11 p.m. The bridge was supposed to be closed to traffic at 9 p.m. but the sentries let Booth and Herold ride through. When challenged Booth gave his right name. It meant nothing to the sentry. It could be surmised that Booth would head south, presumably to some town on the lower Potomac, with the hope of getting across the river into Virginia. He would not be traveling at more than 5 miles per hour, so by this morning—Saturday, April 15, 1865—he could scarcely be more than 40 miles south of Washington. That would put him in Charles County!

The patrols were looking for a man with a limp. Booth had hurt his leg in jumping from

the box to the stage, when his ankle caught in the flag draping the presidential box.

In Bryantown the story was doubly interesting. For in November 1864, John Wilkes Booth had actually come to Bryantown. He had represented himself as a horse buyer. In the course of that business he had met Dr. Samuel A. Mudd.

At that time—the fall of 1864—Booth was hatching a plot to kidnap, though not to kill, President Lincoln. There is some evidence that he invited Dr. Mudd to join him in this plot. If so, Dr. Mudd certainly refused. The doctor never reported the plot. In those days, plots against the President must have been a dime a dozen and perhaps Dr. Mudd did not take Booth seriously.

Yet on his one-night stay in Charles County in November 1864, Booth was an overnight guest at the Mudd farm. And at his trial, Dr. Mudd confessed that, a month later—in December 1864—he met Booth on a street in Washington, and came to Booth's hotel room "to talk about Charles County real estate."

So to Dr. Mudd the melancholy news must have been especially poignant. He guessed then that the patient sleeping at his house was John Wilkes Booth. Now he remembered the old man's beard on the young man's face. And the limp. And the times that coincided so neatly—11 p.m. at the Navy Yard bridge—4 a.m. at Bryantown. And Booth would want to avoid a doctor who might turn out to be a rabid federal. Booth knew that Dr. Mudd was a Southern sympathizer. The beard would be a theatrical prop, of course. Booth was an actor.

Dr. Mudd—now 32 years old—*was* a Southern sympathizer. He had been a slave owner. He said he had voted for Lincoln in 1864.

What was he to do? He could have reported it to the federal authorities—the federal cavalry patrol in Bryantown, for instance. Had he done so, Booth would have been arrested alive and the trial that summer would have been enlivened by dramatic high jinks. But Dr. Mudd was to remain silent for 48 hours—time enough for Booth to get into Virginia.

Dr. Mudd returned to the house at 2 p.m. Some say that he upbraided Booth for his mad act. Some say that he ranted at Booth for involving him in the escape. Others say that he invited Booth to stay and offered to harbor him until his leg healed. What *is* known is this: Dr. Mudd had one of the servants make a crutch; and Dr. Mudd did give Booth an old shoe to wear over the splinted foot. And by 4 p.m., twelve hours after his arrival, Booth was gone.

Next morning, according to Dr. Mudd's testimony, he intended to report the facts to the federal authorities. He waited, however, until Monday. It did not, somehow, seem fitting to betray Booth on Easter Sunday. On Monday he called on Lieutenant Lovett of the federal military police, told him that he had set the leg of a bearded young man, and now—on thinking it over—he believes that the man was Booth. For one week—from April 17 to April 24—they questioned him. Was he in the plot? Had he known about it? Had he ever met Booth before? Here is a photograph. Do you recognize this man? Here is another. Know him? No? That's odd. For this is a daguerreotype of John Wilkes Booth—and that is a likeness of David Herold.

Do you have any clues, any traces? Surely so evil a man must have left a tangible token of his presence.

The boot! Now Dr. Mudd remembered. There it was, forgotten in a corner of the room. And in the boot was written "J Wilkes xxxx." He produced the boot. The officers pounced on it. Why had Dr. Mudd concealed it all this time? To give Booth time to escape? On that day—April 24, 1865—Dr. Mudd was arrested, taken to Washington with shackles on his leg. It would be four tortured years before he saw Maryland again. And on the same day—April 24—Booth arrived at the Garrett farm, the last place on earth he was to see with living eyes.

The trial started only 16 days later. It droned on from May 10 to July 6. Each day, Dr. Mudd and the others were brought in irons, canvas bags over their heads, from the Carroll Prison to the grounds of the Arsenal where the commission sat. The court learned that Samuel A. Mudd had been born in Charles County, Maryland, December 20, 1833. In 1856

the University of Maryland gave him his M.D. degree. In 1858 he married Sara Dyer. He inherited his father's prosperous, slave-run farm. He engaged in private medical practice and he also ran the farm.

They asked him about his strange amnesia. He had forgotten about the boot until it was too late to catch Booth. He had been unable to identify the pictures. He had waited a full 48 hours before he reported to the federal police. Why?

And then there was the fee. Booth had paid Dr. Mudd $25 for services in setting and splinting the leg. So David Herold said, and Dr. Mudd confirmed it. Were these the Judas pieces for a betrayal? Or was this evidence that the Mudd-Booth relationship was a strictly professional one with no political meaning?

AT LAST the trial was over. All eight were convicted. Mrs. Surratt and three of the men —Atzerodt, the carriage-maker, Paine, the Confederate soldier, and Herold, the "Tyson" who had accompanied Booth to Mudd's home —these four were hanged by the neck until dead. Dr. Mudd and two others—O'Laughlin and Arnold—were sentenced to life imprisonment. Spangler, the scene shifter, was given a six year sentence.

Dr. Mudd's guilt has been an arena of controversy ever since 1865. There are those who see him as an innocent martyr to the resentment of the republic, a man whose only crime was to relieve a human being of pain, who did so in the noblest tradition of our profession and in complete ignorance of his patient's guilt. Obviously the news of the shooting of Lincoln could not have reached Dr. Mudd before Booth did. The shooting was at 10 p.m. It was on the wires by 10:45. But there was no telegraph station open in Bryantown that night. Certainly, Dr. Mudd was not a conspirator in the assassination of Abraham Lincoln. So, it might seem as if Dr. Mudd was sentenced to life imprisonment for doing an innocent and simple humanitarian act.

But it is not that simple. Dr. Mudd did harbor Booth *after* he knew his identity. There was evidence that Booth had tried to interest Dr. Mudd in the earlier plot to kidnap Lincoln. Booth had spent a night at Dr. Mudd's farm the previous November—and he had done so at Dr. Mudd's invitation.

Do you invite a casual stranger, a man who might—or might not—want to buy a horse, do you invite him to be your overnight house guest? Was this simply gracious Maryland hospitality to a stranger? Or does it speak for some enterprise in which the two men were jointly engaged?

And then a month later, in the capital city of a war-torn nation, two men, both sympathizers with the enemy, sit down together in a hotel room. To discuss Charles County real estate?

Why did not Dr. Mudd report Booth's presence when he knew that military patrols were scouring the peninsula looking for him? Why did the doctor fashion crutches to facilitate Booth's escape long after he knew that this was the man who killed Lincoln?

So the military commission said: "Guilty." The original plan was to send the prisoners to the federal penitentiary at Watervliet (Albany). But Stanton was obsessed with the fear of a vast Confederate army coming down from Canada and freeing the prisoners. President Johnson was persuaded to change the order. Dr. Mudd and the three other men were placed, under guard, on a steamer to Old Point Comfort. They were then transferred to a gunboat which sailed due east for several hours and then abruptly turned south. The prisoners now knew where they were going. The Dry Tortugas!

Dry Tortugas—the very name has a cruel ring to it! Fort Jefferson, a hexagonal pile of masonry, cooks itself on this parched coral crematory, 120 miles southwest of Florida. The Fort was built there in 1846 to guard the Gulf of Mexico. Planned as "The American Gibraltar," it was fitted with 400 guns facing the mythical enemy from the south or east. The enemy never came. Not one of these 400 guns was ever fired in anger. In 1861 it was converted into a military prison. In 1872 it was abandoned because its wretched health record made it impossible to garrison.

Fort Jefferson is surrounded by a wall fifty

feet high, inclosing a 15-acre courtyard. Around the wall runs a moat, and around the moat runs a breakwater. In 1865, the guards kept a shark in the moat, imprisoned by wire across the sluiceways. The shark was hungry and the guards would throw him a surplus cat now and then. The cat never even got wet. And the prisoners never got out.

There Dr. Mudd was landed on July 25, 1865—three months after he had opened the door to Tyson and Tyler. There he was condemned to spend the rest of his natural life. The other prisoners hooted when Dr. Mudd and his companions crossed the causeway over the moat. "The Lincoln murderers," they were dangerous characters. Perhaps even now a secret army was recruiting in Georgia or Alabama to steam out and deliver them! Dangerous characters who had to be chained to the cell every night.

Dr. Mudd wanted to work as a physician, or at least as a medical technician to help the Fort's doctor. But the commandant said "no." The Lincoln murderer should not be trusted with lives. Since Dr. Mudd had a fair surgical hand, let him put his dexterity to use. He was assigned to the carpenter shop. So it was through the unchanging seasons from July 1865 to July 1867.

Then another epidemic of yellow fever struck the Dry Tortugas. The *aedes aegypti* cannot tell a guard from a prisoner, and bites both. Guards languished and died of the yellow fever and so did prisoners. And Dr. J. Sim Smith, the Fort's lone physician worked day and night to keep out the miasma, to stop somehow the poisonous vapor exuded by the moat. He needed help; and so, after 2 years in the carpenter shop, Samuel A. Mudd became Dr. Mudd once more. The two doctors ignored the buzzing *aedes* mosquito. How were they to know that here was the carrier of yellow fever? Walter Reed was only a 14 year old Virginia boy in 1867—and not until 1900 was the mosquito truly indicted.

Early in 1868, Dr. Smith died and prisoner Samuel A. Mudd was left alone to fight the epidemic. The officers, the guards, the prisoners, all looked to Dr. Mudd to save them. He did what he could and he did well. He sealed the gun ports to keep the miasmi out—and thus he kept out the mosquito. He introduced common sense hygienic measures. But mostly he cared for patients by caring for them, by sitting with them, and bathing the feverish skin, feeding the parched lips. He slept little and labored long. And perhaps through his ministrations, perhaps because it had run its natural course, the pandemic abated, the fury passed, the daily roll of the dead got smaller. By April 1868 the disease had been conquered.

And then the officers of Fort Jefferson sent an appeal to President Johnson. "Pardon Dr. Mudd" they urged, "for he has paid for his trivial part in the conspiracy by a year of loyal labor here." President Johnson took his time. He had troubles of his own, and there were few to press the claims of Dr. Mudd. Finally, on February 13, 1869 (two weeks before he was to turn the keys of the White House over to Ulysses S. Grant), he signed the pardon. Mrs. Mudd had to arrange through her own resources for the delivery of the papers to Fort Jefferson. The document arrived there on March 7, 1869, and the next day a vessel took Dr. Mudd to Key West.

He lived for thirteen years after his release. When he got back to Bryantown he found his estate dissipated. Mrs. Mudd had to use most of their resources in the legal battle, or for the subsequent support of herself and the four children. The old patients had found other doctors. New ones were reluctant to confide in this notorious man to whom clung the odium and odor of assassination. Financially and professionally, Dr. Mudd had a hard time of it. In January 1883 he contracted pneumonia. In those pre-antibiotic days, pneumonia was a death warrant. He died on January 10 at the age of fifty.

The Mudd house still stands on a hill, four miles north of Bryantown. Fort Jefferson has become a national monument. It squats there on the dry Tortugas, stripped of its cannon and its people, a breeding place for black-capped tern.

Essex County Hospital

Trustees Meeting

At its meeting on January 22, 1956, the Trustees:

—Voted to change the name of the Special Committee on Medical Testimony in Liability Cases to the "Special Committee on Medical-Legal Testimony"; and voted to designate the presidential officers as *ex officio* members. In collaboration with a Bar Association committee, this special committee will study the problem and submit a plan for approval.

—Heard the report of the President which included the following items:

—Letter of appreciation was received from the Governor for the representation of our Society in the conference on Salk Vaccine.

—Letter of appreciation was received from Monsignor McNulty for representation at the Seton Hall dinner. In connection with the first television program of "Medical Horizons," sponsored by Ciba and the A.M.A., the president presented a plaque to the Jersey City Medical Center for its cooperation. This plaque was signed by the President of the A. M. A., Dr. Hess. A dinner honoring Dr. J. Lawrence Evans, former Trustee, on his 77th birthday was also attended by the President.

—A problem discussed by the Medical-Legal Liaison Committee was the inability of lawyers to get doctors to testify in malpractice cases. The Bar Association's representatives asked for the assistance of the Medical Society in solving this problem.

—In accordance with the Board's authorization of November 13, 1955, contact was made with the N. J. Federation of Labor and the N. J. Council of C.I.O., to ascertain their interest in the establishment of a Medical Society Liaison Committee with Labor and Industry. The C.I.O. named a representative. The A.F.L. requested further information. Communication will soon be established with the Manufacturers' Association of New Jersey and with the State Chamber of Commerce.

—Confirmed this Society's co-sponsorship of the course in neurosurgical conditions in children. The State Health Department and the New Jersey chapter of the American Academy of Pediatrics are the other sponsors.

—Authorized the President to investigate further the possibility of having the May 14 "Town Meeting of the Air" originate from our Society's general session in Atlantic City.

—Authorized the President to acknowledge a letter from the New Jersey Association of Osteopathic Physicians, asking for conference with our Society on matters of common interest. The President was authorized to indicate our willingness to confer with any group on matters of public health.

—Authorized the Society of Anesthesiologists to use 315 West State Street, Trenton, as their mailing address.

—Adopted the following resolution:

> WHEREAS, Both as a member of the medical profession and as a private citizen Dr. Frederic James Quigley throughout his life proved himself among the most distinguished; and
>
> WHEREAS, By his generous service to The Medical Society of New Jersey—as associate editor of The Journal, member of the Board of Trustees, Executive Secretary to the Subcommittee on Legislation, and President—he endeared himself to the entire Society and left it for all time in his debt; and
>
> WHEREAS, By his death his fellow physicians and his fellow citizens have suffered an irreparable loss; therefore be it
>
> RESOLVED, That The Medical Society of New Jersey record its profound grief at his passing; and be it further
>
> RESOLVED, That a copy of this resolution be spread upon the minutes of this meeting, and that another copy be prepared and presented to his bereaved family.

—Heard, through Dr. Schaaf, a request from the Medical-Surgical Plan. The Trustees of that Plan asked for authorization to make apportionment of available benefits within the ten to fifty dollar range. Dr. Schaaf reminded the Board of the action of the 1955 House of Delegates which approved payment for surgical assistance within a range of not less than $10 and not more than $30 depending upon the surgical procedure. This was an amendment to the proposal of M.S.P. for a range of from $10 to $50 for surgical assistance. However, the current proposal is for other services such as pre- and postoperative care. It is not limited to surgical assistance. This is in conformity with A.M.A. policy and equitable in accordance with the increased fees under the new 1956 contract, to which the range would apply.

The Trustees of The Medical Society of

New Jersey authorized the Medical-Surgical Plan to make such apportionment.

—Heard and received the report of the A.M.A. Delegates. (Details on file in the Executive Offices).

—Received the report of the Executive Officer. Mr. Nevin had attended 26 meetings and conferences and delivered four public addresses since the October session of the Board. The Trustees authorized the Secretary and the Executive Officer to attend the February 7 conference of state and county medical society executives in Chicago.

—Appropriated $30 a year for the next three years as an additional contribution to the New Jersey Safety Council.

—Appropriated $25 for a year's dues in the New Jersey Welfare Council.

—Took actions on the report of the Welfare Committe indicated below.

—Developed a schedule of events for the May 1956 Annual Meeting. (Details will be published in the next issue of this JOURNAL.)

—Authorized the purchase of a new automobile for the Executive Offices, unless satisfactory arrangements could be made for a rental vehicle.

—Authorized the reception of bids for improvement to the driveway.

—Authorized the Executive Offices to poll members with respect to the proposed inclusion of physicians under Old Age and Survivors' Insurance.

—Ruled that an osteopath was not eligible for membership in a component county medical society even though he had an M.D. degree from a foreign medical school, since his New Jersey license derived from his osteopathic degree.

—Adopted the following resolution:

WHEREAS, By his distinguished services as a lawyer and an insurance executive, Harrison Theodore Sorg was outstanding for his furtherance of the welfare of his fellowmen; and

WHEREAS, By his vision and initiative as a pioneer and leader in the development of nonprofit voluntary prepaid hospital insurance in the United States, he has made a unique contribution to that welfare; and

WHEREAS, By his sage counsel and singular sagacity he gave immeasurable impetus and assistance to The Medical Society of New Jersey in the establishment of the Medical-Surgical Plan of New Jersey; therefore be it

RESOLVED, That The Medical Society of New Jersey, honoring him in death as in life, record its profound grief at his passing; and be it further

RESOLVED, That a copy of this resolution be spread upon the minutes of this meeting, and that another copy be prepared and presented to his bereaved family.

Welfare Committee Meeting

The Welfare Committee met on January 8, 1956. Its detailed minutes are available for inspection at the Executive Offices. Here is a summary of its actions:

The Trustees were asked to change the name of the Maternal Welfare Committee to the Special Committee on Maternal and Infant Welfare. The Trustees approved this on January 22.

Received the following from the Subcommittee on Legislation:

1. H.R. 7225—In response to a request from the A.M.A., cooperation was given in a letter-writing campaign to acquaint Mr. Sherman Adams of strong opposition to the passage of H. R. 7225 which would extend social security benefits and establish disability benefits under OASI.

2. A-393—To forbid the sale or possession of hypodermic needles or syringes except on written prescription and to specified persons and institutions. Last spring, our Society recorded itself as applauding the purpose of the bill, but as opposing the measure because it was jeopardizing the welfare of people—such as diabetics—who are dependent upon hypodermic syringes. The bill is approved by the New Jersey State Narcotic Control Commission; it is opposed by the New Jersey Pharmaceutical Association. The subcommittee reaffirmed its original position of disapproval and agreed that a letter setting forth the present position of the Medical Society and explaining the reasons therefor be sent to the New Jersey Narcotic Control Commission.

3. Amendment to Section 24:18-19, R.S.—Purpose of this proposed amendment is to bring the New Jersey Narcotic Law into conformity with a recently enacted amendment to the federal law which permits the dispensing of certain narcotic drugs upon oral authorization of prescriber in conformity with regulations issued by the Commissioner of Internal Revenue. This amendment will not become effective until such regulations have been issued in final form. The opposition of the Narcotic Control Commission is based upon the fear that by abuse of oral prescriptions, narcotic addicts might obtain the drugs thus made

available. The New Jersey Pharmaceutical Association has assured the subcommittee that pharmacists would take steps to ascertain the identity of the physician calling in such a prescription and pointed out that the drugs, listed to be dispensed under the amendment, are not habit-forming. The subcommittee gave particular attention to the accommodation that the procedure of oral prescriptions would afford the physicians and to the assistance that it would give to patients for the prompt relief of pain. It was apparent that the real good which this amendment would provide for the suffering patient, in the opinion of the members of the subcommittee, far outweighed the hypothetical evil that it might do to narcotic addicts who might abuse it. The subcommittee approved the proposed amendment.

The Welfare Committee and, later, our Board of Trustees, accordingly approved the following:

That the proposed amendment to Section 24:18-19 R.S. be approved, and that the position thus taken and the grounds therefor be transmitted to the Secretary of the New Jersey Narcotic Control Commission.

4. S-44—To define patent and proprietary medicines; amends Section 45:14-29 R.S. (Pharmacy Act).

This bill was considered previously by the subcommittee, which recommended that it be disapproved, and the recommendation was concurred in by the Welfare Committee and the Board of Trustees. A letter from a New York attorney, representing the manufacturers of proprietary medicines, urged that the Medical Society reconsider its disapproval. The New Jersey Pharmaceutical Association urged that the position of disapproval be maintained or changed to one of active opposition. The committee reaffirmed its original position of disapproval and authorized the issuance of the following statement to any who inquire about the Society's position on the measure:

The Medical Society of New Jersey has disapproved S-44 because the definition of proprietary medicine as given in the legislation is so very broad as to include some habit-forming and harmful drugs. Moreover, The Medical Society of New Jersey looks with disfavor on any legislation that would relax the salutary controls necessary for the protection of the public.

The Welfare Committee, and later our Board of Trustees, adopted the following:

That The Medical Society of New Jersey reaffirm its disapproval of S-44.

The Executive Secretary of the New Jersey Optometric Association has promised to prepare and introduce amendments to the optometry law to include two changes recommended by the Medical Society and unwittingly omitted at the time A-386 passed through the Legislature in 1954.

The subcommittee directed that a letter of appreciation be sent to Dr. Stewart F. Alexander for his services in connection with proposed legislation governing optometry.

S-397—To amend S-341 to declare it "the policy of the State that no child shall be denied vaccination against poliomyelitis for any reason whatsoever."

The subcommittee voted to take no action on S-397 on the grounds that "this is making policy for the State and its agencies and does not directly affect The Medical Society of New Jersey."

The Welfare Committee and, later, our Board of Trustees approved the following recommendation:

That the position of The Medical Society of New Jersey on S-397 be one of no action.

Bricker Amendment—The October Regional Legislative Conference of the A.M.A. in New York City included further discussion on the Bricker Amendment. The Medical Society of New Jersey is on record as supporting the Bricker Amendment, and the subcommittee will advance this support of the measure at the proper time.

The Committee recommended, and on January 22, the Trustees approved the following:

That a one year subscription to *Today's Health* be sent to the Governor and each member of the State Legislature with the compliments of The Medical Society of New Jersey.

The A.M.A., by resolution at the Boston meeting, is requesting State Societies to survey their members on the question of inclusion of physicians in the Old Age and Survivors Insurance provisions of the Social Security Act.

It was suggested by a member of the Welfare Committee that the Trustees make a clear definition of the subject of the poll. The poll should state it is on the inclusion of physicians in OASI without regard to the county poll taken two years ago and without regard to the provisions of H.R. 7225. Pro and con statements should be sent to all members.

The Welfare Committee concurred in the suggestion, and the chairman directed that it be submitted to the Board of Trustees for consideration.

The following report was received from the Subcommittee on Medical Practice, covering its meeting of December 18.

Licensed Nursing Homes — Upon invitation, representatives of the Licensed Nursing Homes Association of New Jersey, Inc., presented an outline of the facilities available to physicians and their patients in licensed nursing homes in New Jersey. The Association requested the assistance

of the Medical Society in developing and promoting a program of education for physicians and the public to bring to light the facilities available.

The subcommittee recognized there is a need for nursing homes or such facilities, and that they can and do serve a definite function in the care of the sick, especially the chronically ill; however, there is, at the present time, inadequate medical supervision in nursing homes and immediate steps should be taken to improve and correct this inadequacy.

The Welfare Committee approved the following recommendation:

That immediate steps be taken by the Licensed Nursing Homes Association of New Jersey, Inc., to improve and correct the present inadequacy of medical supervision in nursing homes; and that the President refer to the Special Committee on Chronically Ill the request of the Association for assistance in its educational program.

At its January 22 session, the Trustees disapproved of this recommendation, and in lieu thereof adopted the following:

That the Chairman of the Special Committee on the Chronically Ill with the presidential officers and representatives of the Department of Institutions and Agencies explore the present inadequacy of medical supervision in nursing homes and report its findings to our Welfare Committee.

The Welfare Committee, and two weeks later, our Board of Trustees, approved a resolution re-affirming our 1947 position that radiology and the reading of x-ray and fluoroscopy on human beings be recognized as the practice of medicine in conformity with the A.M.A.'s position.

The Welfare Committee, and later the Board of Trustees, approved a resolution empowering the Executive Officer to offer the services of his assistant to county societies for the purposes of evaluating and modifying local public relations programs.

The Welfare Committee, and later the Board of Trustees, approved the following:

As a possible means of improving uniformity throughout the state in the Society's relations with the press, the subcommittee adopted a motion that efforts be made to establish, as an adjunct to the subcommittee, an Advisory Council on Press Relations and Procedures, to consist of about six outstanding representatives of the New Jersey press, with Mr. William McBride, former editor of the Passaic *Herald News* to be invited to serve as chairman of the council.

Regional Blood Banks for New Jersey*

The recommendation of the Blood Bank Commission of New Jersey in its recently published survey[1] is excellent. The number of banks will depend on population density. These regional or centralized blood banks will be integrated with the existing blood banks in each area, and will effect the exchange of blood or blood credits with other regions. The introduction of National Institutes of Health standards in all blood banks would furnish the reciprocal confidence for the exchange of blood among blood banks. The long-range program includes: ready exchange of blood credits, development of good public relations, the problem of cost to the patient, and ultimately, the establishment of regional and state-wide clearing house facilities.

The Blood Bank Committee of the Bergen County Medical Society submits the following suggestions. These are based on our five-year experience in organizing the Bergen Community Blood Bank.[2]

(1) Regional centralized blood banks should be established for administrative and jurisdictional purposes, on county or joint-county lines, when deemed feasible.

(2) Regional blood banks should be administratively separate from existing hospital facilities. They could, if necessary, be based on large, augmented hospital blood banks adapted to the multiple functions of a true "Community" type of blood bank. Their administration should be entirely separate from hospital administrations.

(3) Regional blood banks should be sponsored

*Prepared by the Blood Bank Committee of the Bergen County Medical Society.

1. Moolten, S. E.: Journal of The Med. Soc. of N. J. 52:476 (Sept.) 1955.

2. Journal of The Med. Soc. of N. J.: "The Bergen Community Blood Bank" 53:141 (Mar.) 1956.

by one or more county medical societies, through committees which function in the formulation of policy and in the direction of the centralized blood bank operation and administration.

(4) Strong lay support should be encouraged by representation from prominent individuals and organizations. This will insure financial support and continued interest in the administrative problems of blood banking and donor procurement.

(5) Each regional blood bank should be incorporated under state law as a non-profit, "charitable" organization. A charter and by-laws should be drawn up. Trustees should include equal representation of physicians and laymen.

(6) Initial financing should be developed at the regional level. Each regional organization should make decisions according to its own circumstances and wishes. The problem of operating costs must also be faced. Here are some methods by which these problems have been handled:

(a) Financial support for the initial capital expenses may be raised by a single campaign for funds within the region involved. The regional blood bank when organized thereafter should operate on a self-sustaining basis, the cost of operation being borne by a unit-cost "processing fee." charged and billed to the patient. The Bergen Community Blood Bank was organized in this manner.[2] This is the method of raising capital and initial operating expenses which most of the 70 community blood banks throughout the nation use. This fee-for-service principle, and the responsibility of the patient to replace the blood used, meets the fundamental philosophy of modern medical practice, and has the full support of the American Medical Association.[3]

(b) Funds may be obtained by asking the Freeholders to cooperate with the county medical society by appropriating tax funds. Or municipalities may cooperate in a similar manner. These funds may be augmented by donations and support from other organizations (Community Chests, local Red Cross chapters, and Welfare Federations). This entails annual appropriations to obtain funds for operating expenses. The Essex County Blood Bank is so financed.

(c) Red Cross chapters within a county, with the approval of the American National Red Cross, may aid the medical society or a hospital to form a "permissive" blood program. These projects may run into difficulties for lack of financial support to cover initial capital and subsequent operating expenses. Counties south of Trenton are already covered, for the most part, by the Philadelphia bank, organized and operated by the American National Red Cross. It is supported by annual campaign donations of the public. Therefore, it is basically community-supported, mediated, however, through the Red Cross.

(7) Donor procurement policies must be based on sound actuarial data related to population, and the transfusion rate based on hospital admissions within the region. In addition to the usual replacements and the maintenance of "walking donor" registries, advance deposit of blood for credit should be encouraged on an "insurance" or "reserve" basis, through donor clubs, family, maternity and volunteer donor plans.

(8) The responsibility of the patient or family to replace the blood used cannot be over-emphasized. The alternatives of cash deposit until blood is replaced, or additional blood replacement in lieu of payment of the processing fee, are essential for the dual purposes of keeping the regional blood bank blood-solvent as well as financially solvent.

(9) The National Institutes of Health standards for the collection and storage of blood should be adopted. Licensure by the N. I. H. is hindered by the lack of appropriations for inspections of blood banks. The New Jersey State Department of Health does not license blood banks, but it might be possible for this Department to adopt minimum standards for the technical control of blood banks. Certainly, the Blood Bank Commission should adopt such minimum standards and make proposals as to how they may be enforced.

(10) There should be basic agreements between each regional blood bank and its hospital administrations. Many problems can be settled and policies agreed upon as to blood replacement, credit plans, collection problems, fee schedules, mutual exchange of blood and blood credits.

(11) A state clearing house program should be encouraged. Such programs now exist in Florida, California, Texas, Illinois and New York. Nationwide "Regional Clearing House" programs are planned by affiliated organizations of the American Association of Blood Banks. Every regional and hospital blood bank should be a member of this association.

(12) The American National Red Cross alone should not be involved in blood banking programs in the state and nation. By the combined efforts of the medical profession, the auxiliary agencies and an informed public, together, this job can and will be done.

Dr. Sylvan E. Moolten and the other members of the Blood Bank Commission of New Jersey are to be commended for bringing to the attention of New Jersey physicians their conclusions and recommendations for future action resulting from the 1954 survey.[1] Such a report cannot reveal the vast amount of time, effort and thought which have gone into the accumulation and anaiysis of the blood bank experience of this state.

It is hoped that each County Medical Society will form a Blood Bank Committee to study the needs of is own local area along the lines projected by the Commission's "Survey"; and that such Committees may profit by the experience in Bergen and Essex Counties in the organization and operation of their respective regional blood banks: the Bergen Community Blood Bank, and the Essex County Blood Bank.

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3. Jour. A.M.A. 152:837 (June 27), 1953—A.M.A. Proceedings of the House of Delegates relating to Blood Bank matters.—Resolution on Blood Banking—J. Lafe Ludwig, M.D.

Offices To Be Filled By Election

May 1956

Office	*Term*	*From*		*To*		*Incumbent*
President-Elect	1 year	May	1956	May	1957	Lewis C. Fritts, Somerville
First Vice-President	1 year	May	1956	May	1957	Albert B. Kump, Bridgeton
Second Vice-President	1 year	May	1956	May	1957	Kenneth E. Gardner, Bloomfield
Secretary	1 year	May	1956	May	1957	Marcus H. Greifinger, Newark
Treasurer	1 year	May	1956	May	1957	Jesse McCall, Newton
Trustees:						
2nd District	3 years	May	1956	May	1959	Luke A. Mulligan, Leonia
3rd District	3 years	May	1956	May	1959	Lloyd A. Hamilton, Lambertville
5th District	3 years	May	1956	May	1959	David B. Allman, Atlantic City
11th Trustee	3 years	May	1956	May	1959	William F. Costello, Dover
Councilors:						
1st District	1 year	May	1956	May	1957	F. Clyde Bowers, Mendham
(Unexpired term of Kenneth E. Gardner, resigned; term filled by Board of Trustees to 1956 annual meeting by action on April 20, 1955)						
2nd District	3 years	May	1956	May	1959	Joseph M. Keating, Passaic
5th District	3 years	May	1956	May	1959	Isaac N. Patterson, Westville
A.M.A. Delegates:	2 years	January	1957	December	1958	C. Byron Blaisdell, Asbury Park
	2 years	January	1957	December	1958	J. Wallace Hurff, Newark
	2 years	January	1957	December	1958	L. Samuel Sica, Trenton
	2 years	January	1957	December	1958	Elmer P. Weigel, Plainfield
A.M.A. Alternates:	2 years	January	1957	December	1958	Ralph M. L. Buchanan, Phillipsburg
	2 years	January	1957	December	1958	Jesse McCall, Newton
	2 years	January	1957	December	1958	Herschel Pettit, Ocean City
	2 years	January	1957	December	1958	John H. Rowland, New Brunswick
Delegates and Alternates to Other States:						
New York:						
Delegate	1 year	1957 convention				William F. Costello, Dover
Alternate	1 year	1957 convention				Dorsett L. Spurgeon, Newton
Connecticut:						
Delegate	1 year	1957 convention				Blackwell Sawyer, Toms River
Alternate	1 year	1957 convention				Baxter H. Timberlake, Atlantic City
Standing Committees:						
Finance and Budget	6 years	May	1956	May	1962	Joseph 1. Echikson, Newark
Publication	3 years	May	1956	May	1959	Ralph M. L. Buchanan, Phillipsburg

Surveillance of Poliomyelitis Cases

The national Poliomyelitis Surveillance Program was inaugurated in May, 1955, when poliomyelitis was reported among children who had been injected with the vaccine of one manufacturer. The epidemiologic evidence quickly indicated a cause and effect relationship which warranted the temporary suspension of all poliomyelitis vaccination programs pending the reappraisal of testing procedures.

The amended requirements for the production of poliomyelitis vaccine promulgated by the National Institutes of Health have been directed primarily toward increasing the safety of the vaccine and should eliminate future incidents. However, illnesses characterized by mild systemic disturbances (fever, headache, sore throat, and vomiting) in a group of vaccinated children may raise the suspicion of an unsafe lot of vaccine. Moreover, poliomyelitis may occur among some children who have been vaccinated but for whom the vaccine was ineffective.

If the interval from vaccination to onset is 30 days or less, the question of safety of a particular lot of vaccine must be considered, especially if there is correlation between the site of injection and site of first paralysis.

If the interval from vaccination to onset is more than 30 days, the question of potency of a particular lot of vaccine must be considered, especially if a group of such cases is reported.

It is important that every effort be made to confirm the diagnosis of poliomyelitis. Outbreaks or sporadic cases of a variety of infections such as lymphocytic choriomeningitis, mumps, meningitis, herpes simplex, infection with the Coxsackie virus, eastern and western encephalitis, and leptospirosis may simulate poliomyelitis. Errors in differential diagnosis lead to errors in reporting which lead to erroneously discrediting the vaccine.

To secure the data necessary to determine the effectiveness of poliomyelitis vaccine, to permit a comparison of the general incidence of poliomyelitis in a community with the incidence rate among vaccinated persons, to aid in applying the most effective control measures, certain epidemiologic and laboratory studies will need to be made among individuals who develop poliomyelitis and who have received poliomyelitis vaccine. In such instances, physicians will be asked to furnish pertinent information about poliomyelitis cases under their care, and to cooperate in the collection of blood and stool specimens. The laboratory studies require a great deal of time but when completed physicians will be advised of the results.

This "Surveillance" is being carried out in many other states and the information collected is important for determining the effectiveness of the Salk Vaccine.

We will need the cooperation of all physicians in carrying out this surveillance program.

CARL E. WEIGELE, M.D.
Assistant State Commissioner of Health

1956 ANNUAL MEETING

HADDON HALL, ATLANTIC CITY

Luncheons

These luncheons are in addition to those listed on page 143 of the March JOURNAL.

TUESDAY, MAY 15, 1956 — 12:30 - 2:00 p.m.

Section on Orthopedic Surgery and New Jersey Orthopaedic Society

Reservations: John M. Naame, M.D., 1616 Pacific Ave., Atalntic City

WEDNESDAY, MAY 16, 1956 — 12:30 - 2:00 p.m.

Radiologieal Soeiety of New Jersey

Reservations: George G. Green, M.D., 601 Grand Ave., Asbury Park

New Jersey Chapter, American College of Chest Physicians

Reservations: Lewis F. Baum, M.D., 406 Centre St., South Orange

Obituaries • • •

DR. R. WINFIELD BAESEMAN

In Banda, India, Dr. R. Winfield Baeseman suffered a fatal heart attack on February 1, 1956 while on a tour of duty as a missionary eye surgeon for the Church of Scotland. A member of the Monmouth County Medical Society, Dr. Baeseman devoted much of his time to medical missionary work in the four corners of the world. He developed unusual procedures for the removal of cataracts under varied conditions in India. He made at least ten trips to Asia in connection with his missionary work.

Born in Wisconsin in 1896, Dr. Baeseman earned his M.D. at Louisville in 1927. He had done enlisted service in World War I. He became a diplomate in both ophthalmology and otolaryngology. He was attending ophthalmic surgeon at Fitkin, and senior ophthalmic consultant to the Marlboro State Hospital.

DR. ARTHUR C. BUSH

Dr. Arthur Corbin Bush of Montclair died on February 10, 1956. Born in upper New York State, Dr. Bush was graduated from Syracuse in 1905. After interning in New York City, he came, in 1907, to the then rural community of Verona, N. J. where for fourteen years he served the community as a family doctor. Becoming increasingly interested in anesthesiology, he moved to Montclair in 1921.

Dr. Bush was on foreign duty for the Army during World War I and was a draft board examiner during World War II. He was a Fellow of the American Society of Anesthesiologists, as well as an American Board diplomate in that specialty. Dr. Bush retired in 1953 and was 75 years old at the time of his death.

DR. GUY B. GRIFFIN

Dr. Guy B. Griffin, born in Buffalo, N. Y. in 1898, died in Philadelphia on February 10, 1956. In 1930 he received his M.D. from Tufts, and interned at St. Vincent's in New York. Dr. Griffin was a surgeon, an FACS, and the senior attending surgeon at St. Mary's Hospital in Orange. He was active in church, civic and professional organizations.

DR. JOHN L. HORNER

Dr. John L. Horner of Audubon died after a brief illness on January 20, 1956. Born in Trenton in 1916, Dr. Horner entered the Hahnemann Medical College in 1938. Graduated in 1942, he interned at the West Jersey Hospital in Camden. Dr. Horner was a family doctor, active in committee work in the Camden County Medical Society. He was on the staff of the West Jersey Hospital.

DR. SIDNEY N. MANDELL

At the early age of 42, Dr. Sidney Mandell died at his Union City home on Lincoln's birthday. Decorated for gallantry while serving as a medical corps captain during the "Battle of the Bulge," Dr. Mandell had served during all of World War II. He was senior anesthesiologist at the Fairmount Hospital in Jersey City. A native of Jersey City, Dr. Mandell received his M.D. at Edinburgh. He was on the staff of the North Hudson Hospital and the Margaret Hague Maternity Hospital. He was active in the Hudson County Medical Society.

DR. EDWARD McVAY

Dr. Edward McVay, medical director of the St. James Hospital in Newark, died suddenly on February 23, 1956, at the age of 59. His death occurred only two weeks following a testimonial dinner given to Dr. McVay by his colleagues. Edward McVay was born in Rhode Island and served as a line officer in the Navy in World War I. On being demobilized, he entered the University of Arkansas medical school and received his M.D. degree in 1925. He accepted an internship at Newark's St. James Hospital in that year, and retained his affiliation with St. James for the rest of his life. He was active in the Anatomical and Pathological Society, and, in his private practice was an all-around family doctor, who had developed interest and skill in general surgery.

AUGUSTUS J. MITCHELL

One of north Jersey's colorful medical figures, "Gus" Mitchell died on February 10, 1956 at the age of 88. He was one of the founders of St. James Hospital in Newark, and was the City Hospital's first obstetrician. He was born in Newark in 1868. He worked his way through college as a boilermaker in a foundry. In 1897 he earned his M.D. at Bellevue. He had a busy and variegated general practice in Newark. He was assistant police surgeon, and later chief police surgeon for the city of Newark during the period from 1910 to 1935. Dr. Mitchell was president of the Essex County Medical Society in 1922, and was an early member of the Academy of Medicine. He was in the Physicians' Club of Essex County, the Knights of Columbus and the Newark Athletic Club. For many years he was chief of surgery at the St. James Hospital in Newark.

DR. HARRY H. PETTIT

Ridgewood's pioneer health officer, Dr. Harry H. Pettit died on February 29, 1956 at the age of 73. Born in Washington, N. J., Dr. Pettit was graduated in 1905 from Philadelphia Hahnemann. After interning in the Hahnemann Hospital in Philadelphia, he elected to settle in Bergen County. He attended the people of Ridgewood for half a century. He was the spark-plug of the move to give Ridgewood an organized health department, and he was its first health officer. Dr. Pettit was one of the founders of the Joe Jefferson Club. He was director of the local bank, and active in the affairs of the Bergen County Medical Society. He also engaged in frequent committee activity on behalf of The Medical Society of New Jersey. Until disabled by a stroke in January 1956, he continued faithfully to serve the people of his community in general medical practice.

DR. FREDERICK D. SNYDER

Following several months of illness, Dr. Frederick D. Snyder of Bridgeton died March 7, 1956. He was 29 years of age.

Dr. Snyder was born in Vineland. He attended Vineland High School and was a member of the basketball team and track squad. He served as a pharmacist mate in in the Navy until 1946. He was graduated from Bucknell in 1948 with a Bachelor of Science Degree.

Dr. Snyder entered Hahnemann Medical School and received his degree in 1952.

Dr. Snyder interned at Hahnemann Hospital and came to Bridgeton in July, 1953. He joined Albert B. Kump, M.D. as an associate in the practice of medicine and surgery. In 1955 he entered into practice for himself in Bridgeton, continuing until his illness.

Dr. Snyder was a member of the staff of the Bridgeton Hospital, and of the International College of Surgeons.

Book Reviews • • •

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

Nutrition Practices. Author not named. Published by American Public Health Association, New York 1955 Pp. 80. ($1.00)

New Jersey's own public health commissioner was the chairman of the committee which produced this volume. It describes the role of nutrition in modern public health practice. The responsibility of public health here is essentially educational. The Guide answers such questions as how does a public health administrator use opportunities to carry out his role? How is responsibility shared between public health officials and private practitioners? What is the place of nutrition in the overall structure of a health department? An idea of the book's content may be gained by noting such chapter headings as: program planning for nutrition, planning records and reports, assistance from federal departments, administrative placement, and so on. Many of the chapters are laid out in crisp question and answer form.

HARVEY BLUESTONE, M.D.

Cardiac Diagnosis. Robert F. Rushmer, M.D. Pp. 447. Saunders, Philadelphia, 1955. ($11.75)

Cardiac Diagnosis follows the present trend of physiologic emphasis away from the older anatomic and descriptive treatment of disease. Dr. Rushmer views the anatomic components of the heart, the flow relationships of the circulatory system, the responses to man's unique upright position and the peculiar aspects of the pulmonary circuit. Congestive heart failure is outlined through a physiologic discussion of the cardiac reserve and its derangements.

The section on methods of cardiac diagnosis forms a numerically dominant section of the text. It indicates the author's desire to detect disease at the earliest possible moment so that adequate therapy may be instituted. This interest is, to some extent, dismally colored by Dr. Rushmer's observation that "in spite of a rapidly expanding diagnostic armamentarium, most of the essential information for a complete functional analysis of the heart is not available." Chapters on pressure measurements, roentgenography and heart sounds are absorbing in spite of the "touching of the high spots" technic. The section on electrocardiography is superficial but encompassing.

Cardiac Diagnosis is a physiologist's view of heart disease. It cannot (nor, are we certain, is it meant to) stand alone in the study of heart disease. However, it affords a valuable accompaniment to the more usual texts and journals dealing with heart disease.

ALLEN WELKIND, M.D.

Understanding Surgery. Compiled by Robert Rothenberg, M.D. Pp. 620. New York 1955. Pocket Books, Inc. ($0.50)

It was bound to happen. Sooner or later the soft-cover, low-cost pocket book field would include a surgical text for the layman. This joint product of 8 New York surgeons, this simply written, but not unsophisticated text, takes the voodoo out of operative surgery. It describes the major operations of modern surgery, discusses diagnosis, anesthesia and after care. It groups dozens of practical questions at the end of each chapter. How successful is the operation for detached retina? When, after an appendectomy may I resume marital relations? How long does a patient with a neck fracture wear a cast? And so on.

Each doctor must decide for himself whether to recommend this book to his patients. It will take the edge off fear in many cases, since it does stress the safety of surgery. And many authorities believe that knowledge is always helpful. On the other hand, some feel that we are carrying it too far when we make surgical craftsmanship and surgical diagnosis this simple. And there are even those who think that what medicine needs now in its public relations is more mystery and less behind-the-scenes writing. If you belong to the "tell them the whole story" school, you will find this volume something solid to recommend to your patients. Not every surgeon will buy every page of it, of course. But on the whole, the batting average here is very high.

VICTOR HUBERMAN, M.D.

Principles of Medical Statistics. By A. Bradford Hill, D.Sc. New York 1955, Oxford University Press. (Ed. 6). Pp. 314. ($4.00)

It may make the non-mathematical physician shudder, but the fact is that the solution to most medical problems will have to depend on statistics. The effectiveness of Salk vaccine and the relationship of smoking to cancer are two dramatic current examples. In a sense, the root problem of all medical research is this: are the good results of this new drug (or operation) due to the treatment or could they be due to chance? Common sense gives no answer. Statistical interpretation does.

This inexpensive manual is one of the best of its kind. It tells how to collect data, how to group them, how to present them and how to measure their validity. It has three chapters on fallacies and 16 pages of exercises. (The answers are given in another section.) You will not learn how to do your statistics just by reading this book some night in bed. But if you take it chapter by chapter, reading slowly, doing all the examples to the bitter end, you will emerge as a genuine statistical sophisticate.

HENRY A. DAVIDSON, M.D.

Polio Pioneers: Story of the Fight Against Polio. By Dorothy and Phtlip Sterling. Pp. 128, New York, Doubleday & Co., 1955. ($2.75)

Chilren have been the prime target of poliomyelitis since the first record of the disease 3,500 years ago. This little book relates, in language intelligible to children, the story of the hope, the disappointment and the success of those children stricken with poliomyelitis and those people fighting it.

Hundreds of dramatic historical incidents are as threads woven with considerable grace into the fabric of the story. Ample use is made of similes and metaphors to relate the intricacies of science to the world of the ten-year old. An accurate and stimulating child's history of the progress of medical science, the book ends with the success of Dr. Salk's vaccine but, as is forcefully demonstrated, the story never ends.

A complete index and more than 100 photographs mostly by Myron Ehrenberg and the National Foundation for Infantile Paralysis increase the value of this book for youngsters.

CHARLES F. CHURCH, JR.

Announcements • • •

Special Pediatric Courses

The Philadelphia Childrens Hospital announces the following special courses:

1. Advances in pediatrics. May 28 through June 1. (Fee: $100)

2. Pediatric hematology. June 4, 5 and 6. (Fee: $60.)

3. Blood group incompatabilities. June 7 and 8. (Fee: $50)

For further data, write to Dr. Irving Woltman, 1740 Bainbridge Street, Philadelphia 46, Penna.

Pediatric Oncology

A comprehensive, compact, 3-day course in pediatric oncology, will be available in New York April 25, 26, 27. Held at 444 East 68th Street, this seminar will review the diagnosis and management of neoplastic disease in children. A distinguished faculty has been assembled, and many cases from local hospitals will be presented. The tuition fee is $35. The hours are 8:30 a.m. to 4 p.m. For further details write to: "Pediatric Service, Memorial Center, 444 East 68 Street, New York, N. Y."

Are You Interested in Arthritis?

Arthrology, rheumatology, call it what you will. Are you, as a physician, concerned about diseases of the joints, tendons, bursae and fasciae? If so, the New Jersey Rheumatism Association will interest you. Write to Dr. Herman Tillis at 31 Lincoln Park, Newark; or to Dr. Walter Edwards at 2624 Quaker Bridge Road, Trenton, for membership forms.

National Cancer Conference

The American Cancer Society announces the Third Cancer Conference on June 4, 5 and 6 in Detroit. It will include symposia, lectures, exhibits, clinics, conferences and seminars. For details, write to National Cancer Conference, 521 West 57 Street, New York 19, N. Y.

Physical Therapy Congress

Probably the largest physical therapy colloquium in history is the one scheduled for New York City for June 17 through June 23. Lectures, films, exhibits, case conferences, seminars, courses, study visits, and social events are studded throughout the seven-day program. For details, write to World Confederation for Physical Therapy, 1790 Broadway, New York 19, N. Y.

TB Symposium for GPs

The annual symposium for general practitioners on tuberculosis and other pulmonary disease will be held in Saranac Lake, N. Y. from July 9 to 13. It is approved for 26 hours of credit by the American Academy of General Practice. The faculty includes many distinguished guest lecturers.

Bring your family with you to enjoy the many vacation facilities of the surrounding Adirondack Mountains. So that your wife may have the car, free bus transportation will be provided to the meeting places for the doctors.

Registration fee is $40. Further information is obtained from Dr. Edward N. Packard, P. O. Box 262, Saranac Lake, N. Y.

County Society Reports • • •

Atlantic

The regular meeting of the *Medical Society of Atlantic County* was held at the Children's Seashore House on January 13. The President, Dr. Peter H. Marvel, presided.

Abraham E. Rakoff, M.D., Professor of Gynecologic Endocrinology at Jefferson Medical College, spoke on endocrine therapy.

The business meeting was then opened by President Marvel. The minutes were approved as published in the *Bulletin*. Dr. Molitch reported that the Board of Censors had been very active during the past month. Every effort has been made to prevent legal action against one of our members.

Dr. Timberlake reviewed some of the problems which the legislative committee is trying to settle. The main problem is defeat of H.R. 7225, which deals with expansion of social security. He recommended that the Society write a letter to Sherman Adams, Assistant to the President, stating our disapproval of this bill.

Dr. Salasin stated that the x-ray survey was to be carried out on Absecon Island. Much help will be needed to handle the paper work involved.

Dr. Barry Halpern and Dr. Paul Neidhardt were unanimously elected to associate membership in the Society. Dr. Michael Mendelson was voted into regular membership by transfer.

LEONARD B. ERBER, M.D.
Reporter

Bergen

The *Bergen County Medical Society* held its regular meeting on February 14 at Bergen Pines Hospital with Dr. John E. McWhorter, President, presiding.

Three associate members, Drs. Robert W. Delaplaine, Melvin B. Robbins and Francis P. Salvatore and four regular members, Drs. Grant B. Dellabough, Paul L. Grosner, Gerald Kaplan and C. Stuart Littwin were elected.

A resolution was unanimously passed apologizing to wives and sweethearts in general and to the members of the Auxiliary in particular for separating them from their husband, boy friend, etc. on St. Valentine's Day.

A discussion on a practical working definition of a "medically indigent patient" was followed by a motion to table the proposed definition until it could be determined from counsel that no legal complications were involved.

Robert J. Bell, Attorney for the Medical Society of the State of New York addressed the members on the "Legal Aspect of Medical Practice."

The Nominating Committee report was read by Dr. Thomas DeCecio, Chairman, placing the names of 15 members as Delegates and 15 as Alternates in the class of 1956-58 in nomination, as well as two Alternates in the class of 1955-57 replacing two Alternates of that class, who are now nominated as Delegates in the new class. In addition, nomination was made for the Nominating Delegate and Alternate to The Medical Society of New Jersey Nominating Committee.

JOHN R. WILLIAMS, M.D.
Reporter

Gloucester

The regular monthly meeting of the *Gloucester County Medical Society* was opened on February 16 by the President, Dr. William Beall.

The scientific portion of the program, introduced by Dr. Guy Campo, consisted of a talk by Dr. Harry P. Landis attending ophthalmologist of the West Jersey Hospital in Camden. The subject was "The office management of injuries to the eye." Drs. Ralph Moore and George Booth led a discussion group attending this interesting talk.

The application of Dr. Edward Nash was approved for membership. The Society then approved a resolution to the effect that the Gloucester County Medical Society go on record as demanding deletion of such payments for medical services from the Blue Cross Hospital Plan of New Jersey and any other statement in the Blue Cross Contract implying coverage of medical services and that such services be included in the Blue Shield Medical-Surgical Plan of New Jersey.

Considerable discussion was devoted to the Salk vaccine program. The resolution was finally adopted regarding this program in which all the physicians in each community set a particular time when all medically indigent patients will be given in the individual doctor's office, the Salk vaccine as supplied by the local Board of Health. A memorandum of this resolution was to be forwarded to each Board of Health, and to all county physicians.

ROGER D. LOVELACE, M.D.
Reporter

Middlesex

The regular monthly meeting of the *Middlesex County Medical Society* was held at Roosevelt Hospital, Metuchen, February 15. The meeting was called to order by the President, Dr. Joseph F. Sandella. Dr. B. F. Slobodien, chairman of the Medical Ethics Committee reported on applications for membership from Dr. Bernard M. Bueche, Sayreville, from Delbert D. Griffith, South Amboy and from Dr. Harold W. Potter, New Brunswick.

After appropriate action by the membership at large, these three were accepted into the Associate Membership of the Society. Dr. Slobodien reported that applications for the Hospital Service Plan Group Insurance will be accepted until May 1, 1956.

A communication from The Medical Society of New Jersey as regards federal bill HR 7225 was read to the Society by the Secretary. This urged all members to communicate with their legislators to oppose HR 7225.

On a motion made by Dr. Norman Reitman, the Medical Society gave its endorsement to the blood banks in Middlesex General Hospital, and Perth Amboy General Hospital.

The Society authorized Dr. Sol Gershman to act as Society representative to the Hospital Service Plan of New Jersey.

On a motion by Dr. W. Edgar Sherman, the Middlesex County Medical Society authorized the expenditure of $200 for hotel reservations and activities at the State Medical Society's Atlantic City Annual Meeting.

Dr. Slobodien nominated Dr. Malcolm Dunham of Woodbridge as delegate. On vote, Dr. Dunham was elected.

Dr. Norman Reitman, program chairman introduced Richard A. Bader, M.D., Director, Pulmonary Function Laboratory, Mt. Sinai Hospital, New York, who spoke on "Pulmonary Insufficiency, Physiologic and Therapeutic Consideration." The presentation was an extremely stimulating and informative lecture and brought forth active discussion led by Drs. Moolten, Grossman, and Rosenberg. The Society extends its thanks and gratitude to Dr. Bader for a very informative evening.

S. DAVID MILLER, M.D.
Reporter

Monmouth

The regular monthly meeting of the *Monmouth County Medical Society* was held at Monmouth Memorial Hospital, Long Branch, on February 22, with Dr. William F. Jamison, the President, presiding.

The following officers were elected for the year 1956-1957: Drs. John W. Hardy, President; Theodore Schlossbach, President-Elect; Morton F. Trippe, Secretary-Treasurer; David W. McCreight, Assistant Secretary-Treasurer; Donald W. Bowne, Reporter; Aram A. Captanian, Frank P. Pignataro and Martin R. Rush, Executive Committee.

Active membership status was granted to Drs. L. Glenn Barkalow, Freehold, and Murray Abrams, Deal. Dr. Walter F. Judge, Spring Lake, was elected to associate membership.

A scientific session preceded the business meeting. A panel discussion was held on "New Developments in the Treatment of Malignant Disease." Dr. Harold Kazmann served as moderator. Members of the panel were Drs. Paul Leberman, Associate Professor of Urology; Arthur Finkelstein, Professor of Radiology; Robert Mayock, Associate Professor of Medicine; and Robert Raydin, Assistant Professor of Surgery; all of the University of Pennsylvania Medical School.

DONALD W. BOWNE, M.D.
Reporter

Morris

The *Morris County Medical Society* held its regular February meeting at Warner Chilcott auditorium on February 16. Dr. Harold Hatch, President, was in the chair. A large audience attended and heard Dr. Irving S. Wright speak on "Significance, diagnosis and treatment of disease of the blood vessels." Dr. Wright is clinical professor of medicine at Cornell University Medical School.

The program was presented by the Morris County Chapter of the New Jersey Heart Association for the benefit of the members of the Morris County Medical Society and a very stimulating discussion followed Dr. Wright's presentation.

A short business meeting was held after the program and the new constitutional amendments for the Morris County Medical Society were discussed.

ALBERT ABRAHAM, M.D.
Reporter

Passaic

The monthly meeting of the *Passaic County Medical Society* was held February 21 at the Medical Society Building. Dr. Samuel C. Yachnin, second vice-president, presided.

Dr. Yachnin reported that a letter was received from the Passaic County Homemaker Service, expressing the thanks of its Executive Committee for the donation of $250 received by them from the County Society.

Dr. Yachnin announced that 50 automobile emblems were received by the Society office. He dis-

played one and suggested that these be purchased by the members at $3 each, after the meeting.

He then turned the meeting over to Dr. Henry D. Shapiro who introduced the speaker, Abby Knowlton, M.D., Assistant Professor of Medicine, Columbia University. Dr. Knowlton's topic was "Use of Steroids."

After a question period, refreshments were served by the Woman's Auxiliary.

DAVID B. LEVINE, M.D.
Reporter

Academy of General Practice

On February 19 at the Stacy-Trent Hotel in Trenton, the most successful one-day meeting was held, under the auspices of the N. J. Chapter of the American Academy of General Practice and the newly formed American College of Angiology. The attendance approximated 800.

The wives were entertained by film "Heritage of the Pine Barrens" and a talk by Mr. Frank W. McLaughlin, of the N. J. Audubon Society.

The scientific speakers were as follows:

Dr. A. M. Rabner, who spoke on "The Cerebral Vascular Emergency."

Dr. Shepard Shapiro, who spoke on "Venous Thrombosis."

Dr. Walter S. Priest, who gave a talk on "Congestive Heart Failure."

Col. Byron E. Pollack on "Early Management of Myocardial Infarction."

Dr. Leo Lowe, on "Bacterial and Inflammatory Diseases of the Heart."

Dr. Raymond C. Robinson spoke on "Cutaneous Manifestations of Peripheral Vascular Diseases."

HARRY TAFF, M.D.
President

Auxiliary Report • • •

Gloucester County

The *Woman's Auxiliary to the Gloucester County Medical Society* met at the home of Mrs. Paul Pegau on January 19. Plans were made for our Scholarship Dance at the Woodbury Country Club on April 7 for the benefit of the Nurse's Scholarship.

On January 28 our annual "Husbands' Party" was held at the home of Mrs. A. Guy Campo. A covered dish supper was served. Dr. Louis R. Collins showed films of his trip to Europe. Thirty couples were present.

On February 19 a business meeting was held at the home of Mrs. B. A. Livengood. Mrs. Louise Stoerrle spoke to the group on principles of safety. Mrs. Denham showed films on accidents in the home. Literature was distributed.

Gloucester County was listed in the Exclusive Club with 111 per cent in *Today's Health* contest.

MRS. ROBERT C. PUFF, President

Allergic Colds

Patients who complain that they catch one cold right after another, or that once they catch a cold it hangs on and on, may be suffering from a basic allergic process, maintain Drs. Jack R. Anderson and Wallace Rubin of New Orleans. In such cases symptoms are not accompanied by constitutional manifestions of upper respiratory infections. Often the symptoms persist in spite of antibiotics. Treatment can be considerably shortened and needless medicament avoided if the basic allergy were recognized and treated. The full article appears in the November 1955 issue of *Clinical Medicine.*

TUBERCULOSIS *Abstracts*

Supplied by New Jersey Trudeau Society

ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXIX April, 1956 No. 4

The Tuberculin Test

By Floyd M. Feldmann, M.D., Medical Director, National Tuberculosis Association,
NTA Bulletin, *October, 1955.*

The time has come for a closer look at the tuberculin test as an aid to tuberculosis control and eventual eradication. What can it do and what are its limitations? Should every community have a testing program? Unfortunately, simple answers to such questions cannot be provided from the information now available. Those who attempt the best use of this tool must study their own problems in the light of the known facts and must follow this with studies of the results obtained by practical experience. This may sound formidable but will not be too difficult if consideration is given to some guiding principles.

The tuberculin test properly done is one of the most specific and reliable tests known to medicine. With few exceptions, persons who harbor live tubercle bacilli in their bodies will have an easily demonstrable skin sensitivity to the unique proteins produced by these organisms.

This fact makes it possible to identify actual or potential victims of the disease. The test does not reveal the location of the infection in the body, its extent, its activity, or when it might become a threat to health.

Nevertheless, the tuberculin test is widely used for three major purposes. First of all, it is used for diagnosis. When a person has suggestive findings, a negative test is good evidence that tuberculosis is not responsible for the illness. If the test is still negative when repeated after 30 days, tuberculosis can be ruled out. A positive test is not so conclusive because many people harbor tubercle bacilli in their bodies without symptoms and without significant harm to their health. However, a positive test is of great value in arriving at a diagnosis if it is known to have become positive recently, and even single positive tests are significant in young children and in population groups where infection rates are low.

Secondly, the test is used for information on the status of tuberculosis control efforts. Over a period of years, the tuberculin test will provide reliable measures of new infections taking place and therefore indirectly, of the number of active open cases of tuberculosis not under treatment. The epidemiological information obtained is useful in determining which population groups need attention.

Thirdly, the test is used to screen out those individuals who have been infected. This use of the tuberculin test as a first step in finding hidden cases of the disease is at once simple and complicated. Its efficient utilization depends on many factors.

For screening purposes in case finding the intradermal test (Mantoux) is preferred. For technical details see the 1955 edition of "Diagnostic Standards and Classification of Tuberculosis," published by the National Tuberculosis Association.

Under some circumstances "patch" tests may be preferred. In this country the "Vollmer" patch test is commercially available and has been most commonly employed. The appearance of a reaction to the patch test is different from that resulting from an intradermal test so the reader must be experienced in making interpretations.

In general the patch test is regarded as being less sensitive than the intradermal test, and to be

less satisfactory for testing individuals over the age of 12. If the intradermal test is to be used, a standardized preparation of P.P.D. is preferred. However, O. T. is still being used by many with satisfactory results. The cost per dose is extremely small for either one.

The advantages of intradermal testing are: 1. With good technique few reactors will be missed. 2. The dosage and depth of administration can be accurately controlled. 3. Within 72 hours, the test can be read with precision and may be measured. 4. The test cannot be removed accidentally or tampered with. 5. It is inexpensive.

The disadvantages are: 1. Some people have an aversion to the use of a needle (a good preliminary education program will ensure close to 100 per cent participation in most communities). 2. Special and sterile equipment is necessary. 3. Tuberculin solutions do not maintain potency more than a few days. 4. The test can be given only by trained personnel, usually physicians.

The favorable aspects of patch tests are as follows: 1. No needle is used. 2. No special equipment or sterilization is necessary. 3. The prepared patches remain potent for several months without refrigeration. 4. Under supervision the patches may be applied by volunteers.

Unfortunately, there are also some unfavorable aspects: 1. The patch test is not as sensitive as the intradermal test and some reactors will be missed. 2. The dose of tuberculin cannot be controlled and a few severe reactions occur as well as false negatives. 3. The interval between test and reading is longer than that of the intradermal test. 4. The patch test is more difficult to read than the intradermal test. 5. Precise measurements of the reactions are impossible. 6. The patches frequently become detached either from tampering or by accident. 7. The patch test is more expensive per individual tested.

Those who are planning the program must decide which groups in the population should be tested. Theoretically if one is to discover all infected individuals, everyone in the community should be tested, and in some less populous areas this has been attempted. No one has had the temerity to try it in large cities, however. A sampling of various groups in the population may be practical and valuable if done with expert statistical guidance. Communities vary tremendously and no one formula will fit all communities. It is important that a program to determine infection levels and trends in a community include adults as well as children. Current testing programs so frequently neglect the adult population from which come the bulk of tuberculosis cases.

A testing program limited to school children will give some indication of the amount of active tuberculosis in a community. Again the ideal would be to test all children every year. If all children cannot be tested every year, expert opinion seems to favor annual testing of children entering school, a grade midway, such as the sixth, seventh or eighth, and those about to leave school (usually twelfth graders). This will give some information on infection rates and will provide some basis for case finding among the contacts of new reactors.

The school testing program offers an opportunity to tuberculin test all teachers, bus drivers, food handlers, custodial and maintenance employees who are in close contact with the children. Although the percentage of active cases in these adults will be small, there are many reports of sharp epidemics of tuberculosis in schools traceable to a teacher or other employee with unsuspected active disease.

Examination of all older children and adults by x-ray without a preliminary skin test is simpler and will reveal conditions other than tuberculosis but provides no basis for epidemiological follow-up. It would be preferable to give tuberculin tests and chest x-rays to everyone in this older group.

Editor's Note: This is the first of two abstracts on the tuberculin test. The second will be the May issue of Tuberculosis Abstracts.

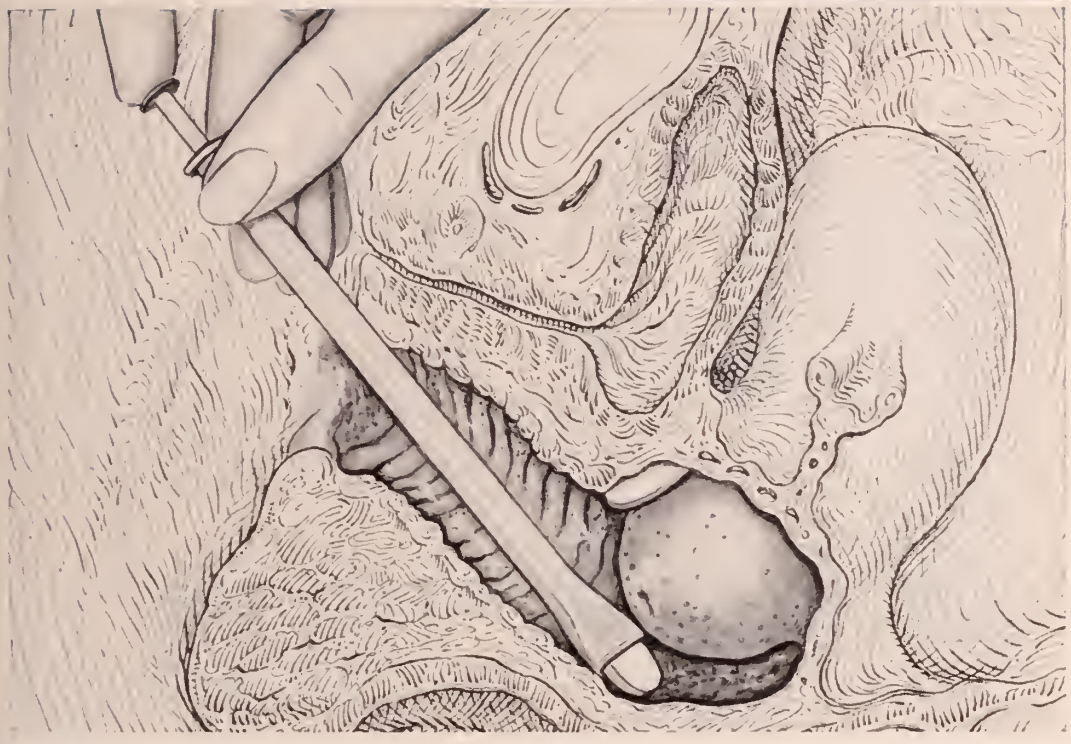
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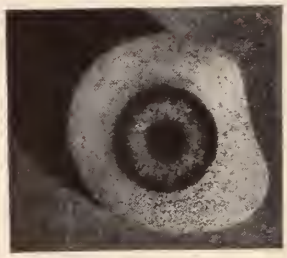
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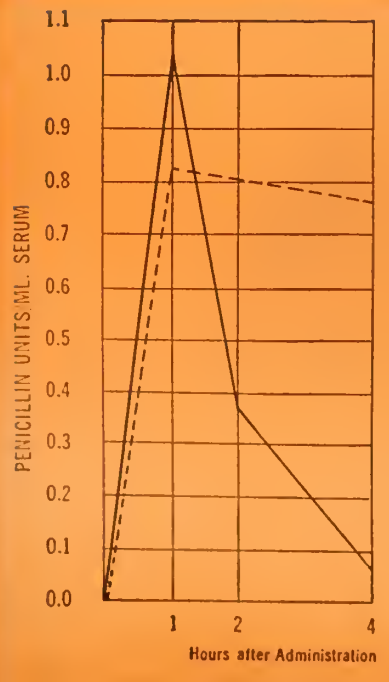
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2. Moyer, J. H.; Dennis, E., and Ford, R.: Drug Therapy (Rauwolfia) of Hypertension. II. A Comparative Study of Different Extracts of Rauwolfia When Each Is Used Alone (Orally) for Therapy of Ambulatory Patients with Hypertension, A.M.A. Arch. Int. Med. *96*:530 (Oct.) 1955.

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BRIEF OUTLINE OF COVERAGE

(THE COMPLETE TERMS OF THE INSURANCE COVERAGE ARE SET FORTH IN THE POLICY)

ACCIDENTAL BODILY INJURY BENEFIT —Full monthly benefit for total disability, from FIRST DAY, limit 60 months. One-half monthly benefit for partial disability, limit 6 months. Limit of time for total and partial combined 60 months. (Total disability coverage extendable to lifetime.†)

SICKNESS BENEFITS —Full month benefit for total disability commencing with EIGHTH DAY of disability, limit 24 months, house confinement not required. Total disability coverage extendable to 7 years.†)

(Regular care and attendance by a legally qualified physician or surgeon, other than yourself, required during period of disability.)

ARBITRATION CLAUSE —The Committee on Medical Defense and Insurance of the Medical Society of New Jersey are the SOLE arbiters in the event of any claim disagreement between Company and Policyholder.

CONDITIONS OF RENEWABILITY —Once issued, the policy cannot be ridered for recurrent disability nor can it be terminated so long as the Society plan is in existence, except for non-payment of premium, if the insured retires or ceases to be actively engaged in the Medical profession, if he ceases to be an active member of The Medical Society of New Jersey, or if renewal is refused on all policies issued to all members of the society, in which event 60 days prior notice in writing must be given.

EXCEPTIONS —Suicide or intentionally self-inflicted injury, or any attempt thereat, while sane or insane; injury due to hazards of warfare; injury due to air travel, except while a fare paying passenger, as described in the policy, are not covered.

ANNUAL PREMIUM RATES*

(Applicable to ages at entry and attained at annual renewal of insurance)

Monthly Benefits	Dismemberment Benefits	Ages up to 50 Next Birthday	Ages 51 to 60 Next Birthday	Ages 61 to 65** Next Birthday
$100.00	$ 5,000	$ 29.50	$ 34.00	$ 43.00
150.00	7,500	43.60	50.35	63.85
200.00	10,000	57.70	66.70	84.70
300.00	15,000	85.90	99.40	126.40
400.00	20,000	114.10	132.10	168.10
500.00	20,000	141.30	163.80	208.80
600.00	20,000	168.50	195.50	249.50

* Premiums may be paid half-yearly or quarterly, pro-rata.

* All rates above INCLUDE $1000 Accidental Death Benefit.

** Although the age limit for acceptance of risks is the 65th birthday, once issued there is no termination age limit for renewal.

† Extension of sickness benefits to seven years and accident benefits for life available to holders of the above policy under age 60, in accordance with the Company's underwriting regulations, through the new EXTENDED PROFESSIONAL DISABILITY POLICY which is renewable to the 65th birthday. Ask about its coverage and modest additional cost.

Issued Exclusively by

NATIONAL CASUALTY COMPANY

Through

E. and W. BLANKSTEEN

AUTHORIZED DISABILITY INSURANCE REPESENTATIVES OF THE MEDICAL SOCIETY OF NEW JERSEY

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THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 12, 1766

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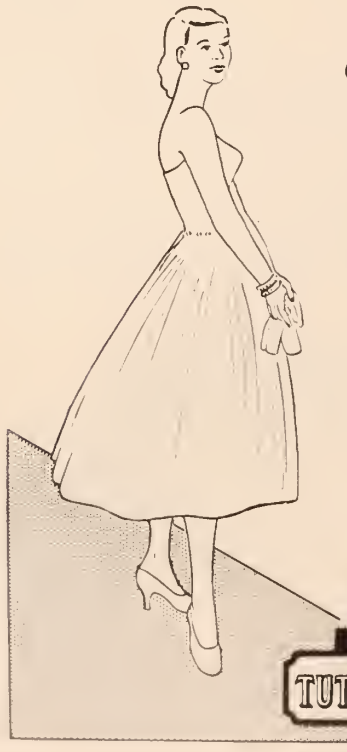
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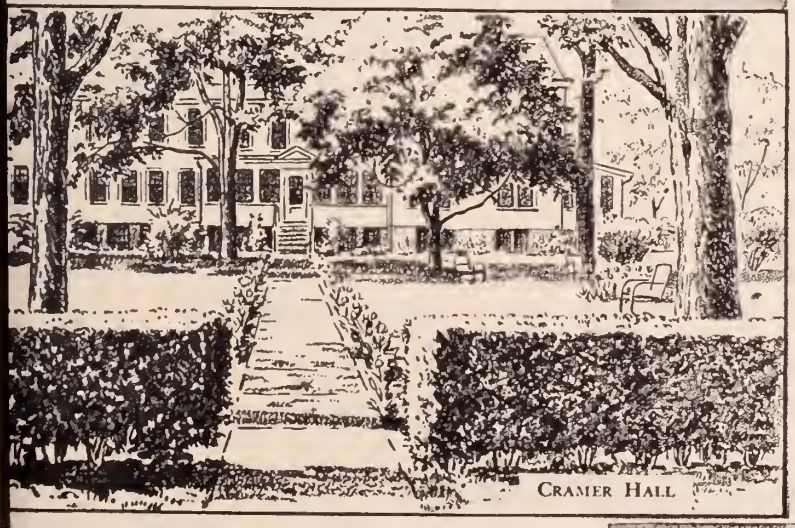
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Telephone—Belle Mead 21

DOCTORS EVERYWHERE NOW KNOW WHY

Viceroys Are Smoother

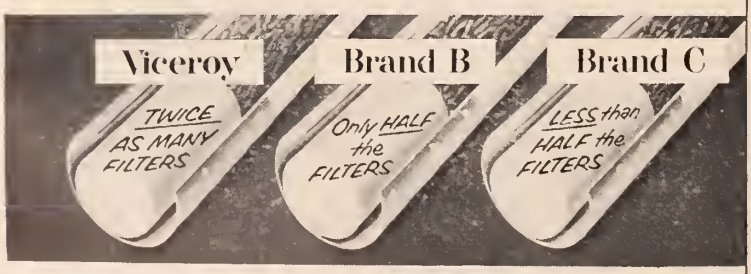


Professional men who have studied the microscopic analysis of the Viceroy filter now know why the Viceroy taste is smoother—never rough. Only Viceroy has 20,000 tiny filters in every tip—twice as many filters as the other two largest-selling filter brands. That is why Viceroys are smoother by far—never, never rough. That is why so many doctors now smoke and recommend Viceroys.

Yes, smoother taste because there are

TWICE AS MANY FILTERS IN EVERY VICEROY TIP

as the other two largest-selling filter brands!



Viceroy's exclusive filter is made from pure cellulose—soft, snow-white, natural!





now what?

Every call is a new challenge. If you find the patient has a bacterial infection you may, like many physicians, think of Gantrisin 'Roche' first. For Gantrisin is highly soluble, well tolerated, and effective against a wide range of pathogens.

Gantrisin® - brand of sulfisoxazole



How many of your patients are clams?

... most youngsters to be sure -
and many oldsters, too - who balk at pills.

Gantrisin (acetyl) Pediatric Suspension solves the problem because its delicious raspberry flavor appeals to all ages, while the wide spectrum and extensive clinical background of Gantrisin assure you of effective, well-tolerated antibacterial therapy.

Gantrisin® - brand of sulfisoxazole
Gantrisin®(acetyl) - brand of acetyl sulfisoxazole



ROCHE Original Research in Medicine and Chemistry

Introducing

A.P.C. WITH Demerol® Tablets

for more efficient

CONTROL OF *Pain*

Each tablet contains:

Aspirin	200 mg.	(3 grains)
Phenacetin	150 mg.	(2½ grains)
Caffeine	30 mg.	(½ grain)
Demerol hydrochloride	30 mg.	(½ grain)

Average Adult Dose: 1 or 2 tablets
repeated in three or four hours as needed.

Bottles of 100 tablets. *Narcotic blank required.*

"Such a combination has proven clinically to be far more effective and no more toxic than equivalent doses of any of these used singly."*

Winthrop LABORATORIES
NEW YORK 18, N. Y.

*Bonica, J.J.; and Backup, P.H.: Northwest Med., 54:22, Jan. 1955.

emerol, trademark reg. U.S. Pat. Off., brand of meperidine, – May be habit forming

NEW DEVELOPMENTS IN TELEPHONES

for patients with impaired hearing or partial voice loss



1 A NEW TYPE AMPLIFIER PHONE offers new convenience to the partially deaf. The quality of amplification has been improved through the use of new developments in transistors, and the overall sound level has been stepped up. The range of amplification is from 0 to 22 decibels. A very efficient receiver also contributes to greater clarity of reception.

The new model amplifier phones can also be used on rural and four-party lines. The volume can, of course, be adjusted for normal use.

$1.25/mo. additional

2 BONE CONDUCTION RECEIVERS. Occasionally people with impaired hearing get better results using a bone conduction receiver. This is a special headset for use with the new type amplifier phones and is available with or without a cut-off key.

25c/mo. additional without key
40c/mo. additional with key

3 LOUD RINGING BELLS are available if the standard telephone bell cannot be heard.

35c/mo. additional

Extension bells and other types of audible signals are also available for other rooms in the house.

4 VISUAL SIGNALS. Special visual signals can be set up. One very effective visual signal is a neon light that operates directly from ringing current. When the phone rings, the lamp lights.

35c/mo. additional

5 PATIENTS WITH VOICE IMPAIRMENT can get phones that amplify their voice. This is accomplished by a special conversion of the hard-of-hearing set so that the amplifier is in the *transmitting* circuit.

Rates similar to that for amplifier phone.

For more detailed information, or to answer any questions, simply call the Service Representative at your Telephone Business Office.

NEW JERSEY BELL TELEPHONE COMPANY

your patient should not be endangered by fluid accumulation during "rest periods"

YOUR PATIENT NEEDS AN ORGANOMERCURIAL

When a diuretic must evoke acidosis to be effective, continued administration without dosage limitation results in refractoriness. Other diuretics may require interrupted dosage to avoid gastrointestinal irritation.

But the sustained diuresis achieved by the organomercurials never necessitates routine "rest periods" because of their mode of action.

TABLET **NEOHYDRIN®**

BRAND OF CHLORMERODRIN (18.3 MG. OF 3-CHLOROMERCURI-2-METHOXY-PROPYLUREA EQUIVALENT TO 10 MG. OF NON-IONIC MERCURY IN EACH TABLET)

a standard for initial control of severe failure **MERCUHYDRIN® SODIUM**
BRAND OF MERALLURIDE INJECTION

01256

LAKESIDE



little

How to win friends ...



The Best Tasting Aspirin you can prescribe.

The Flavor Remains Stable down to the last tablet.

15¢ Bottle of 24 tablets (2½ grs. each).

We will be pleased to send samples on request.

THE BAYER COMPANY DIVISION

of Sterling Drug Inc.

1450 Broadway, New York 18, N. Y.

in rheumatoid arthritis



STANDING

is easier with STERANE[1]—3-5 times more potent than hydrocortisone or cortisone.[2]

WALKING

follows rapidly.[1] STERANE "is more effective than any previous drug in the control of...rheumatoid arthritis."[3]

WORKING

functional mobility is restored even where other steroids fail or cease to be effective.[2,3]

WITH MINIMAL DISTURBANCE

of electrolyte balance[1-3]—patients may even be treated without diet restrictions.

Sterane®

brand of prednisolone

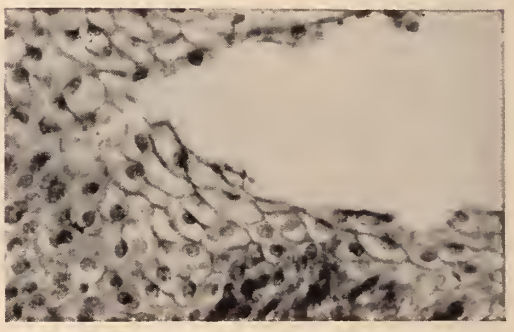
supplied: *White, 5 mg. oral tablets, bottles of 20 and 100. Pink, 1 mg. oral tablets, bottles of 100.*

1. Spies, T. D., et al.: GP 12:73, No. 1, 1955. 2. Boland, E. W.: J.A.M.A. 160:613, 1956. 3. Gillhespy, R. O. Lancet 2:1393, 1955.

PFIZER LABORATORIES Division, Chas. Pfizer & Co., Inc. Brooklyn 6, New York

HOW VAGISEC LIQUID
PENETRATES
RECESSES OF VAGINA AND EXPLODES TRICHOMONADS OFTEN MISSED

Photomicrograph of section of epithelium of normal vaginal mucosa, enlarged 750 times, shows uneven surface where trichomonads hide. VAGISEC penetrates surface and explodes organisms in hard-to-reach areas.



TOO OFTEN AN ORDINARY trichomonacide fails to cure vaginal trichomoniasis because it has little or no effect on parasites that are not on the surface.[1] Trichomonads burrowed deeply into the roughened mucosa survive and set up new foci of infection. In fact, even a few hidden trichomonads remaining after treatment can cause acute exacerbations. With VAGISEC® liquid and jelly you can overcome this most troublesome problem.

Penetrates thoroughly — This new and unique trichomonacide spreads out and wets the entire vaginal surface. It rapidly dissolves mucinous materials, fats and blood clots.[1] It penetrates the cellular debris that lines the vaginal walls and shields the parasites, reaching trichomonads deep in their hiding places.

Explodes trichomonads — VAGISEC liquid actually explodes trichomonads within 15 seconds after douche contact.[2] Two surface-acting agents and one chelating agent combine to weaken the cell membrane, to remove the waxes and lipids, and to denature the protein. With its cell wall destroyed, the parasite imbibes water, swells and explodes. All this occurs within 15 seconds. Only scattered fragments remain.

Proves highly effective — With the Davis technique† you can now rid patients of "trich," even cases that have resisted other treatment. VAGISEC liquid was developed as "Carlendacide," by Dr. Carl Henry Davis, M.D., noted gynecologist and author, and C. G. Grand, research physiologist.[1] Clinical trials by more than 150 physicians show better than 90 per cent success.[3]

Use liquid and jelly — In the Davis technique, VAGISEC liquid is used in office therapy. At the same time, liquid and jelly are prescribed for home use. They are well tolerated, leave no messy discharge or stain.

Office treatment — Expose vagina with speculum and wipe walls dry with cotton balls. Then wash thoroughly with a 1:100 dilution of VAGISEC liquid. Remove excess fluid with cotton balls. Dr. Davis recommends six treatments.

Home treatment—Patient douches with VAGISEC liquid every night or morning and then inserts VAGISEC jelly. Home treatment is continued through two menstrual periods, but omitted on office treatment days. Douching contraindicated in pregnancy.

One course of treatment—"If the treatment has been accomplished as directed," the patient "will have no flagellates provided the infection was limited to the vaginal canal . . . A few women have infected cervical, vestibular or urethral glands and require other types of treatment."[4] Continued douching with VAGISEC liquid two or three times each week for eight to twelve weeks helps prevent re-infection.

Prevents coital re-infection — Infected husbands are ". . . a potential source of re-infection in wives successfully treated."[5] Prescribe for your patients the protection afforded by Schmid high quality condoms. Specify the superior RAMSES® rubber prophylactic, transparent, tissue-thin, yet strong. If there is anxiety that rubber might dull sensation, prescribe XXXX (FOUREX)® prophylactic skins, of natural animal membrane, pre-moistened.

Active ingredients in VAGISEC liquid: Polyoxyethylene nonyl phenol, Sodium ethylene diamine tetra-acetate, Sodium dioctyl sulfosuccinate. In addition, VAGISEC jelly contains Boric acid, Alcohol 5% by weight.

References: 1. Davis, C. H., and Grand, C. G.: Am. J. Obst. & Gynec. 68:559 (Aug.) 1954. 2. Davis, C. H.: J.A.M.A. 157:126 (Jan. 8) 1955. 3. Davis, C. H.: West. J. Surg. 63:53 (Feb.) 1955. 4. Davis, C. H. (Ed.): Gynecology and Obstetrics (revision), Hagerstown, W. F. Prior, 1955, vol. 3, chap. 7, pp. 23-33. 5. Lanceley, F., and McEntegart, M. C.: Lancet 1:668 (Apr. 4) 1953.

JULIUS SCHMID, INC.
gynecological division
423 West 55th Street, New York 19, N. Y.

VAGISEC, RAMSES and XXXX (FOUREX) are registered trade-marks of Julius Schmid, Inc.
†Pat. App. for

looked over often...

the patient with nonspecific rheumatism

NOW—thoroughgoing relief with

NEW SIGMAGEN TABLETS









combining

Prednisone	0.75 mg.	—best of the new
Acetylsalicylic acid . . .	325 mg.	—best of the old
Ascorbic acid	20 mg.	
Aluminum hydroxide . .	75 mg.	

antirheumatic • anti-inflammatory • analgesic • supportive

Combined effectiveness of the antirheumatic agents in SIGMAGEN permits maintenance of clinical relief at minimal dosages.

SIGMAGEN,* brand of corticoid-analgesic compound.
*T.M.

Schering

SG-J-51

WHY SENSITIZE

in topical and ophthalmic infections

USE 'POLYSPORIN'®

brand

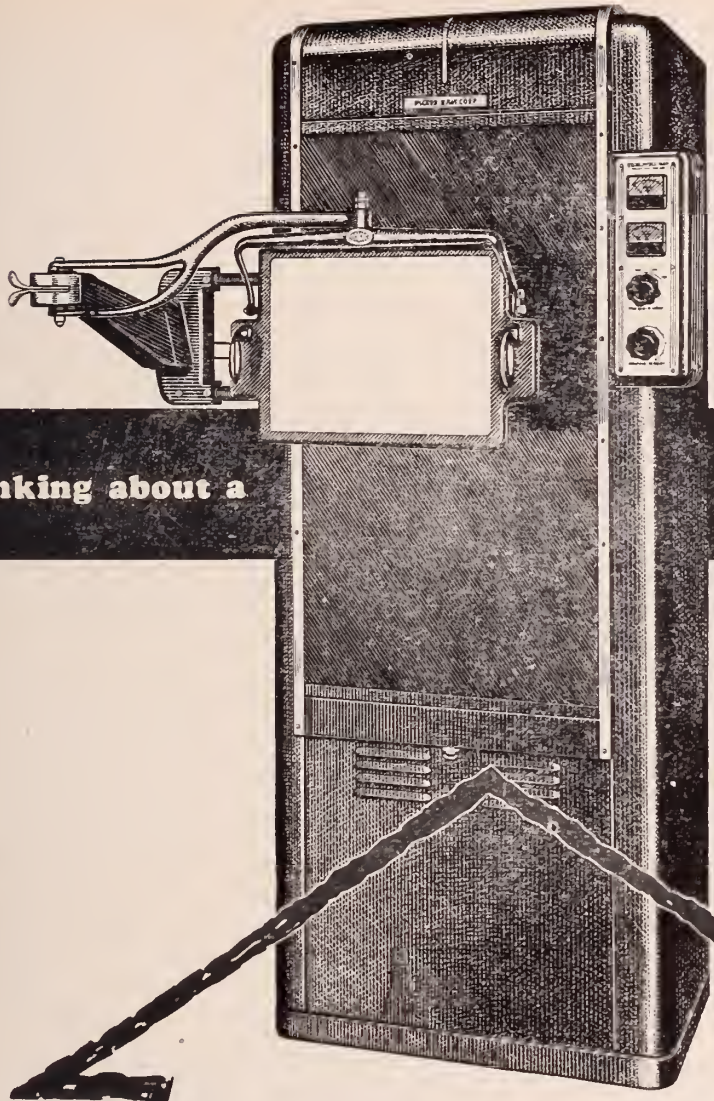
POLYMYXIN B—BACITRACIN OINTMENT

to insure broad-spectrum therapy with minimum allergenicity

For topical use: in ½ oz. and 1 oz. tubes.
For ophthalmic use: in ⅛ oz. tubes.



BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N. Y.



thinking about a new fluoroscope?

get a fine one... the little more it may cost* will pay off handsomely in the long run. A fine Picker fluoroscope like this will serve you efficiently for many a long year. It is built by the same skilled craftsmen to the same high standards as the Picker apparatus used in three out of four Medical Schools and Teaching Institutions in the U. S. and Canada.

**You can rent it (or any other Picker apparatus) if you'd rather.*

Picker x-ray

25 South Broadway, White Plains, N. Y.

Picker x-ray apparatus is backed by a service organization without peer in the field. There's a local Picker office near you, ready to serve you well and promptly in anything having to do with x-ray.

EWARK 2, N.J., 972 Broad Street
ncoln Park, N.J., Sewaros Avenue
ılington, N.J., 186 Belville Pike

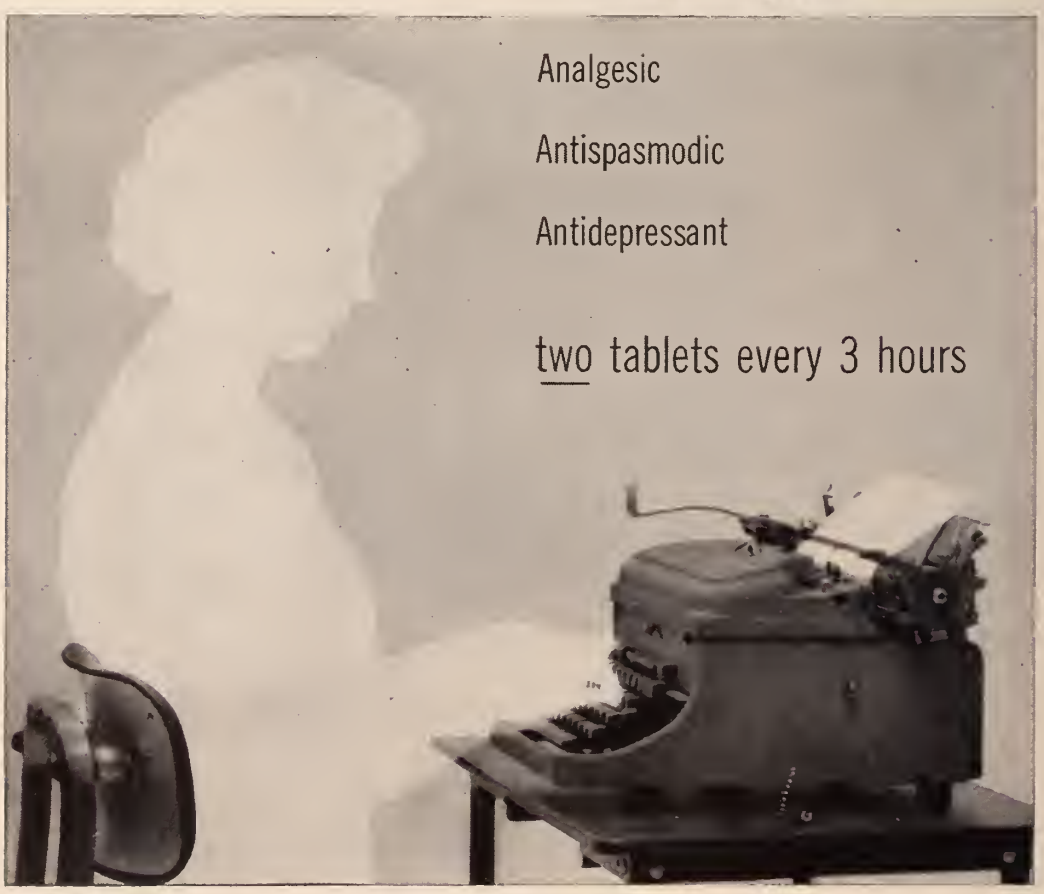
Matawan, N.J., 52 Edgemere Drive
Philadelphia 4, Pa., 103 S. 34th Street
(Southern N.J.)

"140 million working hours are lost annually as a result of

dysmenorrhea"[1]

Before menstruation begins, for sure relief of dysmenorrhea prescribe

Edrisal*

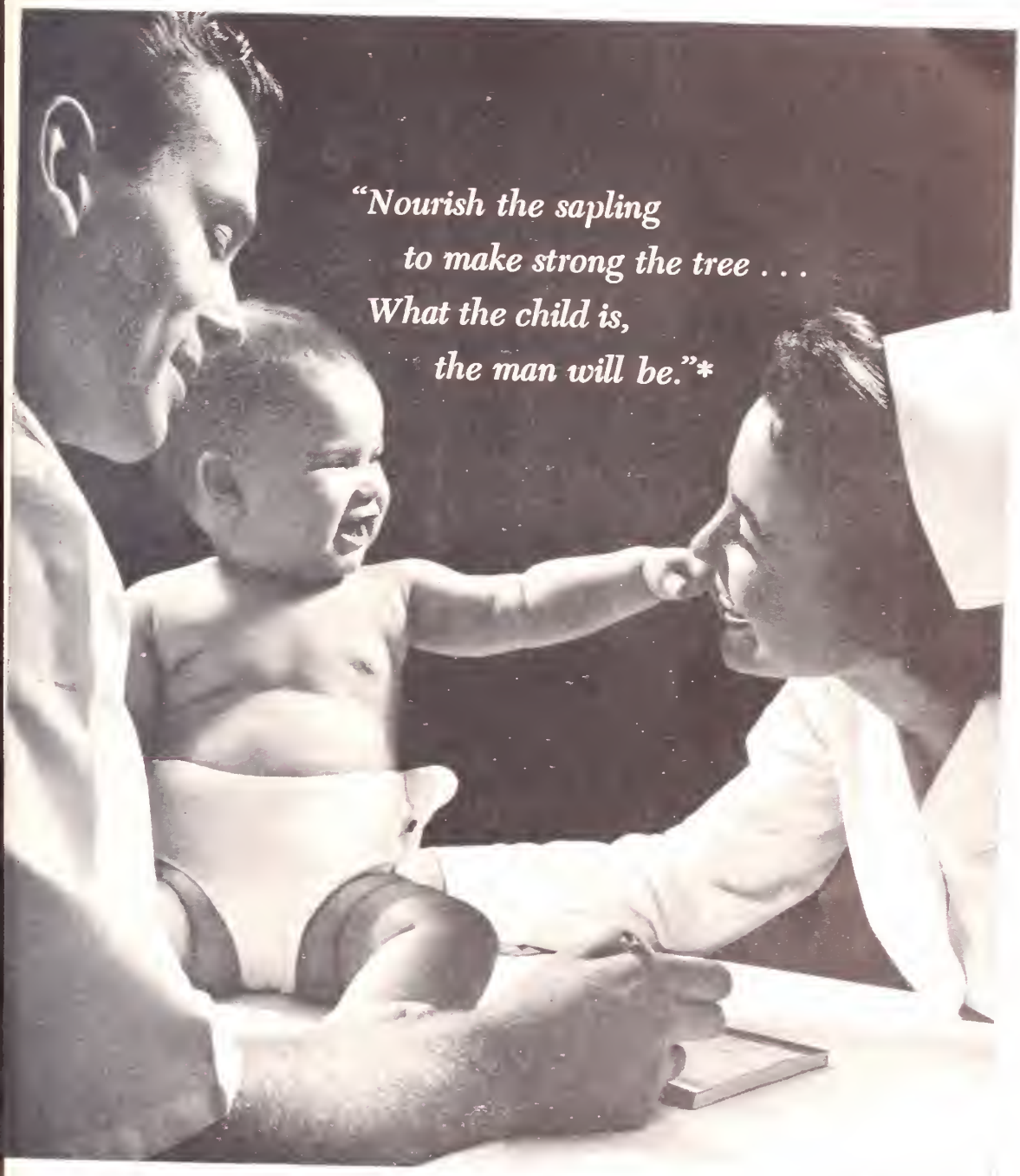


FORMULA: Each 'Edrisal' tablet contains:

Benzedrine* Sulfate (racemic amphetamine sulfate, S.K.F.)	2.5 mg.
Aspirin	2.5 gr.
Phenacetin	2.5 gr.

Smith, Kline & French Laboratories, Philadelphia

I. M. Times 76:416 *T.M. Reg. U.S. Pat. Off.



You can specify PABLUM with confidence

All physicians appreciate the strictness of pharmaceutical standards. Pablum Cereals are the *only* baby cereals made by nutritional and pharmaceutical specialists. All four Pablum Cereals are enriched with thiamine, riboflavin, calcium, phosphorus, copper, and with iron in its most assimilable form



Now available in these bright new packages

Pablum Products DIVISION OF MEAD JOHNSON & COMPANY EVANSVILLE IND.



The above advertisements appeared recently in Life, Saturday Evening Post, and Today's Health.

"How to look at a doctor's bill" could well serve as the title for recent Parke-Davis advertisements on the cost of medical care. For they suggest to the public new ways of looking at the extraordinary *value* one buys with each dollar spent for prompt and proper medical care.

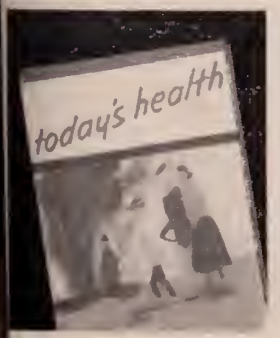
These Parke-Davis messages talk in everyday language about familiar but "forgotten" facts. Some examples: the steadily decreasing cost of curing diseases such as pneumonia, the phenomenal reduction in the death-rate for children, the substantial savings in time and income because of the shortened duration of hospital stays.

By highlighting the heartening facts of medical progress in relation to the cost of medical care, this new series hopes to help in creating a healthy, realistic public opinion on the reasonableness of medical costs.

To do this successfully, we wish the facts to have the widest possible readership. Therefore these advertisements are being published regularly in such mass-circulation magazines as LIFE, the SATURDAY EVENING POST, and TODAY'S HEALTH.

If you would like to have folder-size reprints of any of these ads for your reception room, we will be happy to supply them on request.





PARKE, DAVIS & COMPANY

Detroit 32, Michigan

PROFESSIONAL LIABILITY PROTECTION

Afforded Members of

THE MEDICAL SOCIETY OF NEW JERSEY

SINCE 1921

FAULHABER & HEARD, Inc.

Authorized broker to negotiate
professional liability contracts for
The Medical Society of New Jersey

CONSULT US

For Protection and Specialized Service

200 Washington Street — Newark, N. J.

Telephone MItchell 2-3214

FAULHABER & HEARD, Inc.

200 WASHINGTON STREET — **NEWARK, N. J.**

Kindly send information on limits and costs of Society's Professional Policy

Name .....

Address .....

.....



HydroCortone® -T B A

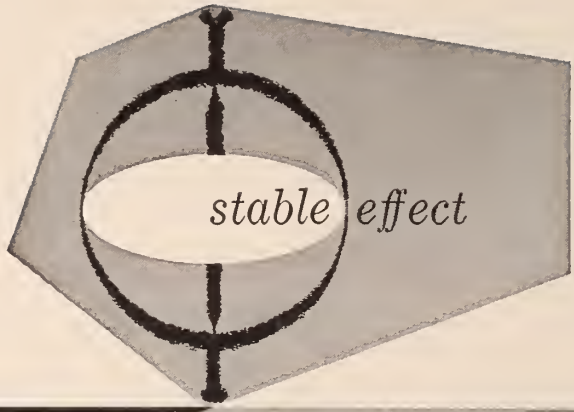
(HYDROCORTISONE TERTIARY-BUTYLACETATE, MERCK)

gives the arthritic patient more days of freedom from joint symptoms—in many patients the anti-rheumatic effect persists 2 to 10 times longer than after injection of hydrocortisone acetate. Its action is local and without systemic effect.

SHARP & DOHME

Philadelphia 1, Pa.
DIVISION OF MERCK & CO., INC.

SUPPLIED: SALINE SUSPENSION HYDROCORTONE TBA 25 MG./ML. VIALS OF 5 ML.



RAUDIXIN

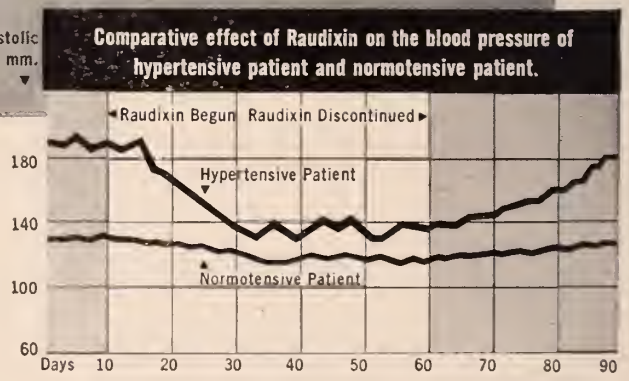
SQUIBB WHOLE ROOT RAUWOLFIA SERPENTINA

in anxiety and tension states . . .
stable ataractic (tranquilizing) effect
without excessive sedation

in hypertension . . .
stable hypotensive effect without rapid peaks and declines in blood pressure

DOSAGE: 100 mg. b.i.d. initially; may be adjusted within a range of 50 mg. to 500 mg. daily. Most patients can be adequately maintained on 100 mg. to 200 mg. daily.

SUPPLY: 50 mg. and 100 mg. tablets, bottles of 100, 1000 and 5000.



The hypotensive action of Raudixin is selective for the hypertensive state. For this reason, Raudixin does not significantly affect the blood pressure of normotensive patients.

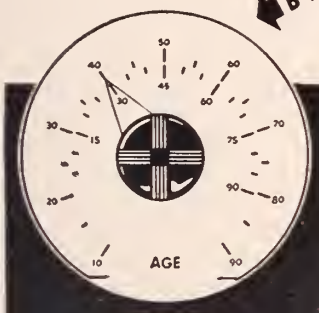
SQUIBB

"RAUDIXIN"® IS A SQUIBB TRADEMARK

WE'VE GREATLY *Simplified* IT FOR YOU, DOCTOR . . .

BY SETTING THESE DIALS . . . .

AND PRESSING THIS BUTTON







ALL DIALS: MALE—Outer scale; FEMALE—Inner scale

THE L-F BASALMETER

Self-Calculating

Basal Metabolism Apparatus

With this new, efficient BMR apparatus, you put in *four* factors (age, height, weight and sex) and the patient puts in the *fifth*—the time factor. The BasalMeteR computes these factors electrically and gives you an accurate basal metabolic rate.

THERE ARE NO CHARTS, NO GRAPHS, NO SLIDE RULES, NO "WHEEL" CALCULATORS, NO CONVERSIONS, NO HEAVY OXYGEN TANKS!

L-F

HOLD BUTTON DOWN TO READ BM RATE

YOU READ THE BM RATE RIGHT HERE



Here is a long-awaited, long-needed simplification in metabolism test apparatus! No "wondering" about human error with the BasalMeteR. At conclusion of the test. you press a button and read the result in terms of a plus or minus in pereentage of normal. It's as simple as that, and just as reliable. Find out now, without obligation, about this newer, better BMR unit!

MAIL THIS COUPON *Today!*

THE LIEBEL-FLARSHEIM CO.,
Cincinnati 15, Ohia NJ

Gentlemen: Please send me, without obligation, your 6-page brochure describing the new L-F BasalMeteR.

NAME_____

ADDRESS_____

CITY/STATE_____

Meat...

and the Rehabilitation of Protein Depleted Patients

Although the recommended daily allowance of one gram of protein per kilogram of body weight is adequate for the average healthy adult,[1] greater amounts may be needed in the rehabilitation of patients depleted in protein after severe infections, mechanical trauma, burns, or extensive surgery.[2] Protein needs for tissue regeneration during convalescence are high.

To speed rehabilitation of the protein depleted patient, top quality protein and calories should be given in generous quantity.[2] However, a high protein intake, 130 grams daily, at best induces a slow response.[3] Intakes at 3 or 4 times that level may produce considerably more rapid gain in weight, strength, and morale.[4,5] If mastication and swallowing are difficult, canned strained meats—such as used in infant feeding—may be used to advantage in the high protein diet.[2]

Lean meat, outstanding in contained top quality protein, may well be made the keystone of the high protein diet. Its abundance of vitamin B complex and essential minerals—iron, phosphorus, potassium, and magnesium—adds to its therapeutic value. Important also are its appetite appeal, its easy digestibility, and its virtual freedom from allergenic properties.

1. Recommended Dietary Allowances, Washington, D. C., National Academy of Sciences—National Research Council, Publication 302, 1953.
2. Co Tui: Review: The Fundamentals of Clinical Proteinology, J. Clin. Nutrition *1*:232 (Mar.-Apr.) 1953.
3. Keys, A.; Brozek, J.; Henschel, A.; Mickelsen, O., and Taylor, H. L.: The Biology of Human Starvation, Minneapolis, Univ. of Minnesota Press, 1950.
4. Burger, G. C. E.; Drummond, J. C., and Sandstead, H. R.: Malnutrition and Starvation in Western Netherlands, The Hague General State Printing Office, 1948, Part II, p. 91.
5. Co Tui; Kuo, N.H.; Chuachiaco, M., and Mulholland, J.H.: The Protein Depletion (Hypoproteinia) Syndrome and Its Response to Hyper-Proteinization, Anesth. & Analg. *28*:1 (Jan.-Feb.) 1949.

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

American Meat Institute
Main Office, Chicago...Members Throughout the United States

clinical advantages with

TETRACYN®

BRAND OF TETRACYCLINE



- rapid absorption and distribution to all parts of the body
- prompt, broad-spectrum action against infections caused by gram-positive and gram-negative bacteria, spirochetes, certain large viruses and protozoa
- minimal incidence of adverse reactions
- available in a wide selection of convenient dosage forms for oral, parenteral or topical use

Tetracycline the nucleus of modern broad-spectrum activity discovered and identified by Pfizer scientists

Pfizer®

PFIZER LABORATORIES
Division, Chas. Pfizer & Co., Inc.



Now Diaper Service for Hospitals

BABY SERVICE HAS CREATED AN OUTSTANDING HOSPITAL SERVICE DIVISION

Offering:

Now serving many of New Jersey's Leading Hospitals.

- **Daily pick-up and delivery.**
- **Same diapers returned.**
- **Diapers treated with residual antiseptic.**
- **Charge is only for diapers actually used.**
- **Featuring *new* DEXTER NO-FOLD diapers.**



FOR THE SAFETY OF YOUR BABY...

Baby Service

For complete information, write . . . or telephone

HUmboldt 4-2700

124 SOUTH 15th ST.
NEWARK 7, N. J.

Branches:

Clifton—GRegory 3-2260
ASbury Park 2-9667
MOrristown 4-6899
PLainfield 6-0056
New Brunswick—CHarter 7-1575
Jersey City—JOurnal Square 3-2954
Englewood—LOwell 8-2113

Also Individual Diaper Service for the Home

We gratefully acknowledge the advice and co-operation of many physicians in helping us to plan and supply a SUPERIOR SERVICE.

Washed Separately • Dried Separately • Packed Separately

- The container we furnish for used diapers sprinkles its soiled contents with an efficient antiseptic solution whenever the container lid is opened and closed.
- All plant operations are carefully supervised. A chemical check is continuously made, and bacteria colony counts of the diapers are run.
- A modern tested diaper supply service for our customer's exclusive use.



Safe! Individual! Dependable!

Reduces Muscular Tension

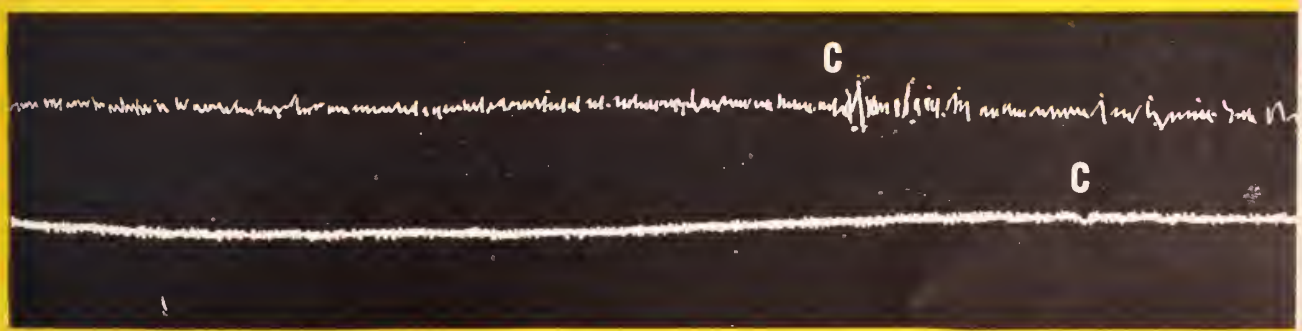
Equanil*

MEPROBAMATE

(2-methyl-2-*n*-propyl-1,3-propanediol dicarbamate)

Licensed under U.S. Patent No. 2,724,720

Electromyography shows decisive response



Electromyographic study of neuromuscular hyperactivity in 42-year-old male with anxiety-tension syndrome. A, Before EQUANIL; action potential of high amplitude and frequency. B, After one week of ambulatory treatment with EQUANIL; showing definite reduction in tension, greater ability to relax, and marked improvement in muscular coordination. C, Point where patient makes effort to relax.[1]

The remarkable effectiveness of EQUANIL may be demonstrated in two ways. One is by its ability to relieve muscle spasm and neuromuscular tension.[1] The second is by its ability to relieve mental tension and anxiety.

Usual dosage: 1 tablet t.i.d. The dose may be adjusted either up or down, according to the clinical response of the patient.

Supplied: Tablets, 400 mg., bottles of 50.

1. Dickel, H.A., et al.: West. J. Surg., April, 1956.

anti-anxiety factor with muscle-relaxing action . . . relieves tension

Wyeth®

Philadelphia 1, Pa.

*Trademark



"The Edison Voicewriter helps me do more for my patients—and spend time with my family too"

"No more a stranger to my family—thanks to the **VOICEWRITER**"

"I'm a pediatrician—but the kids I used to see the least—were my own.

"We're becoming buddies now, though . . . because three months ago I got an Edison Voicewriter.

"The Voicewriter saves me hours of time. Helps me quickly bring case histories up-to-date. I take it with me in the car—dictate my patient report after making each call. It's three times faster . . . and my case histories are more complete, more valuable—because they're done while the facts are fresh!"

Why don't you find out more about this modern electronic assistant? Just call your Edison business consultant. His phone listing is Market 2-8052. Find out, too, about Edison Televoice, electronic telephone dictation used by today's most modern hospitals.



Less than $15.00 a month puts an Edison Voicewriter on your desk. Lease it . . . buy it. Chances are this electronic assistant will cost less than your telephone service

THOMAS A. EDISON INCORPORATED 1066 Broad St., Newark 2, N. J.

All the benefits of prednisone and prednisolone plus positive antacid action to minimize gastric distress



Multiple Compressed Tablets of 'Co-Deltra' and 'Co-Hydeltra' are designed to help the physician cope with the problem of gastric distress which might otherwise become an obstacle to therapy with the newer steroids prednisone and prednisolone. Each Multiple Compressed Tablet is specifically formulated as a "tablet within a tablet" to provide stability and to release in sequence antacid and anti-inflammatory components.

NEW

'Co-Deltra'

Prednisone Buffered

MULTIPLE COMPRESSED TABLETS

and

'Co-Hydeltra'

Prednisolone Buffered

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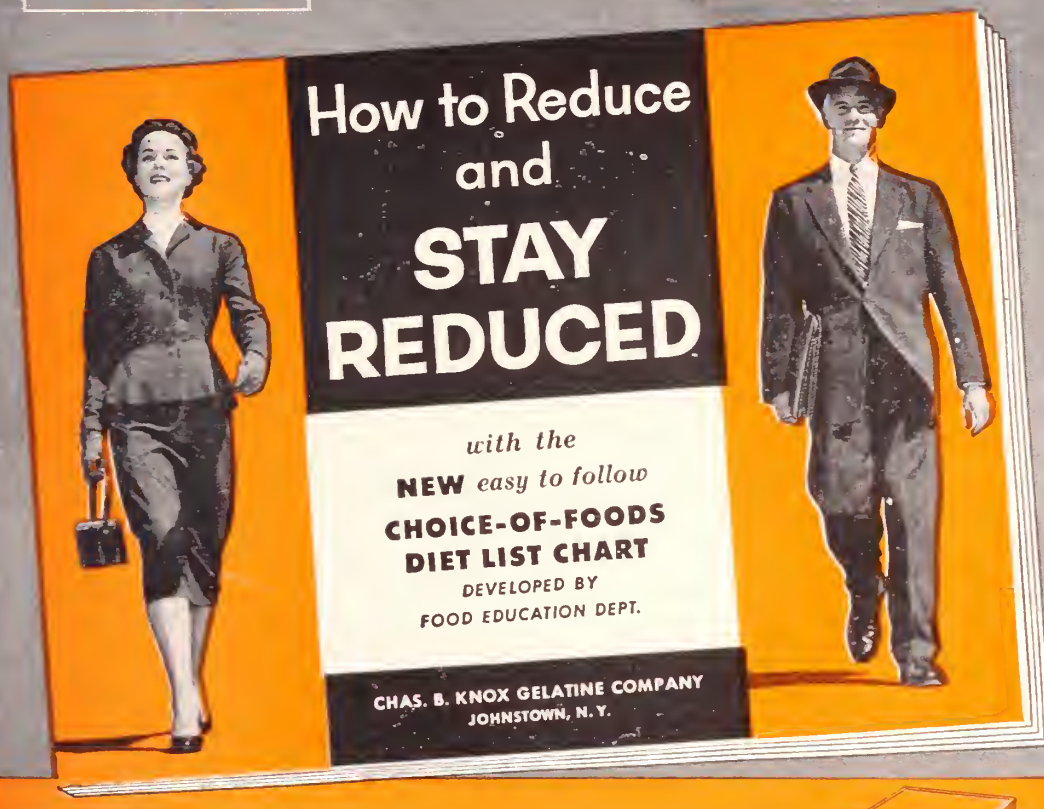
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New Booklet Available to Aid Management of Overweight Patients



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To help patients persevere in their reducing plans, the last 14 pages of the new Knox booklet are devoted to more than six dozen *tested*, low-calorie recipes. Please use the coupon below to obtain copies of the new "Eat-and-Reduce" booklet for your practice.

1. Developed by the U. S. Public Health Service assisted by committees of The American Diabetes Assn., Inc. and The American Dietetic Assn.

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Professional Service Dept. SJ-17
Johnstown, N. Y.

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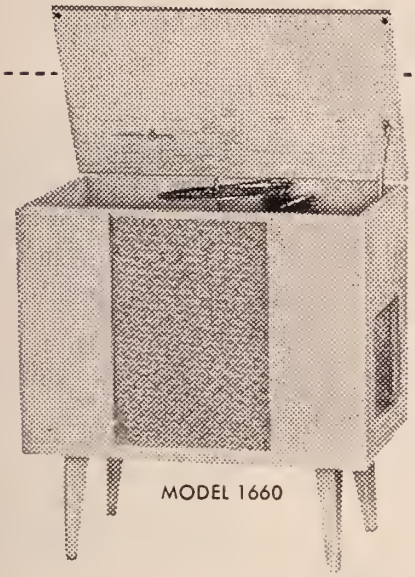
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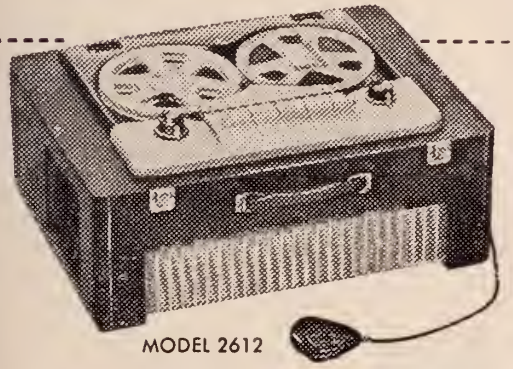


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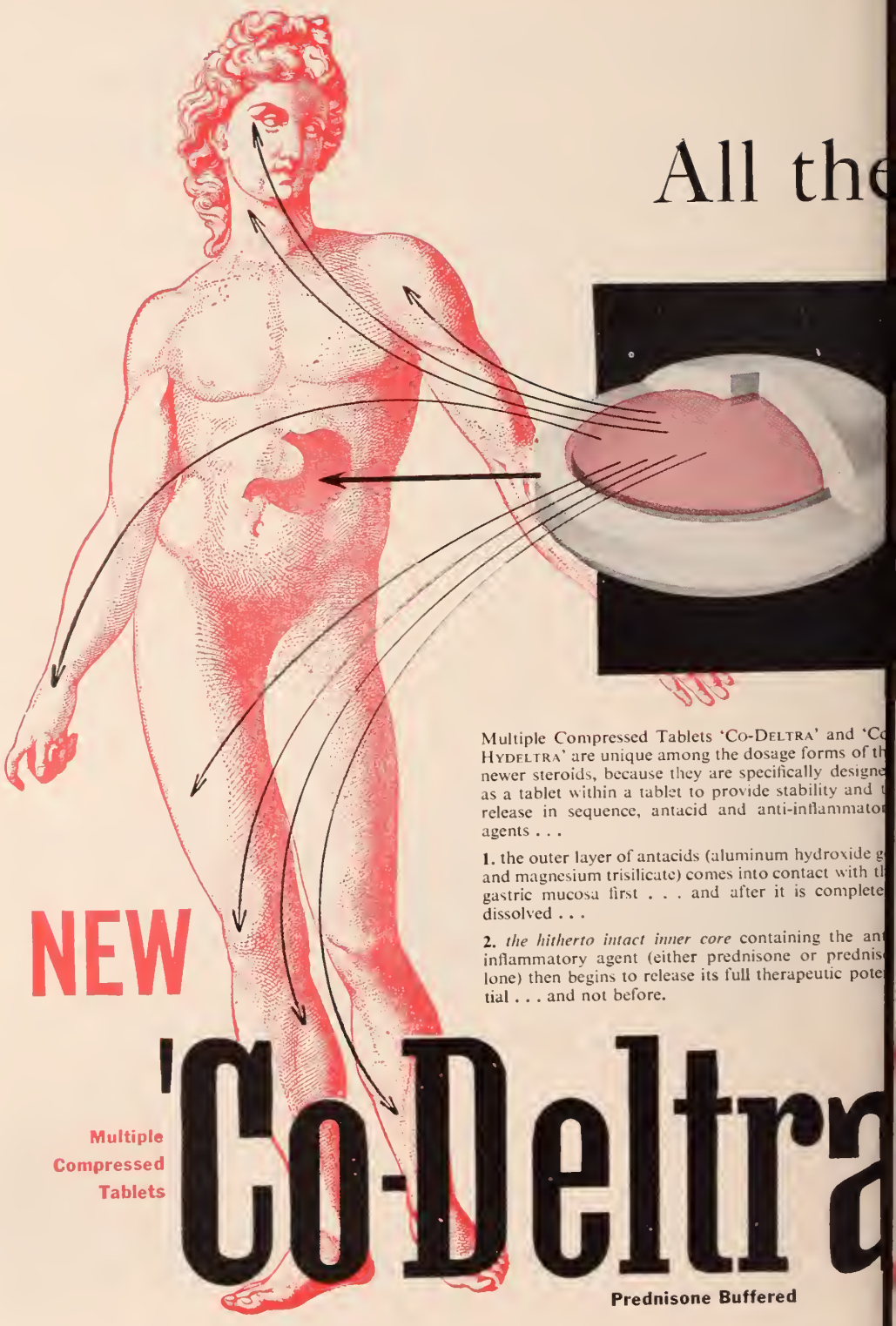
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1. Bollet, A. J., Black, R., and Bunim, J. J.: *J.A.M.A.* **158**: 459, June 11, 1955.

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[1]January, H. L. et al: Clinical experience with tetracycline. *Antibiotics Annual* 1954-55, p. 625.

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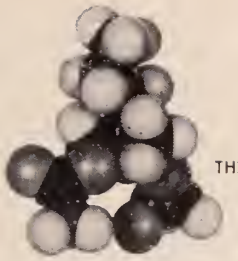
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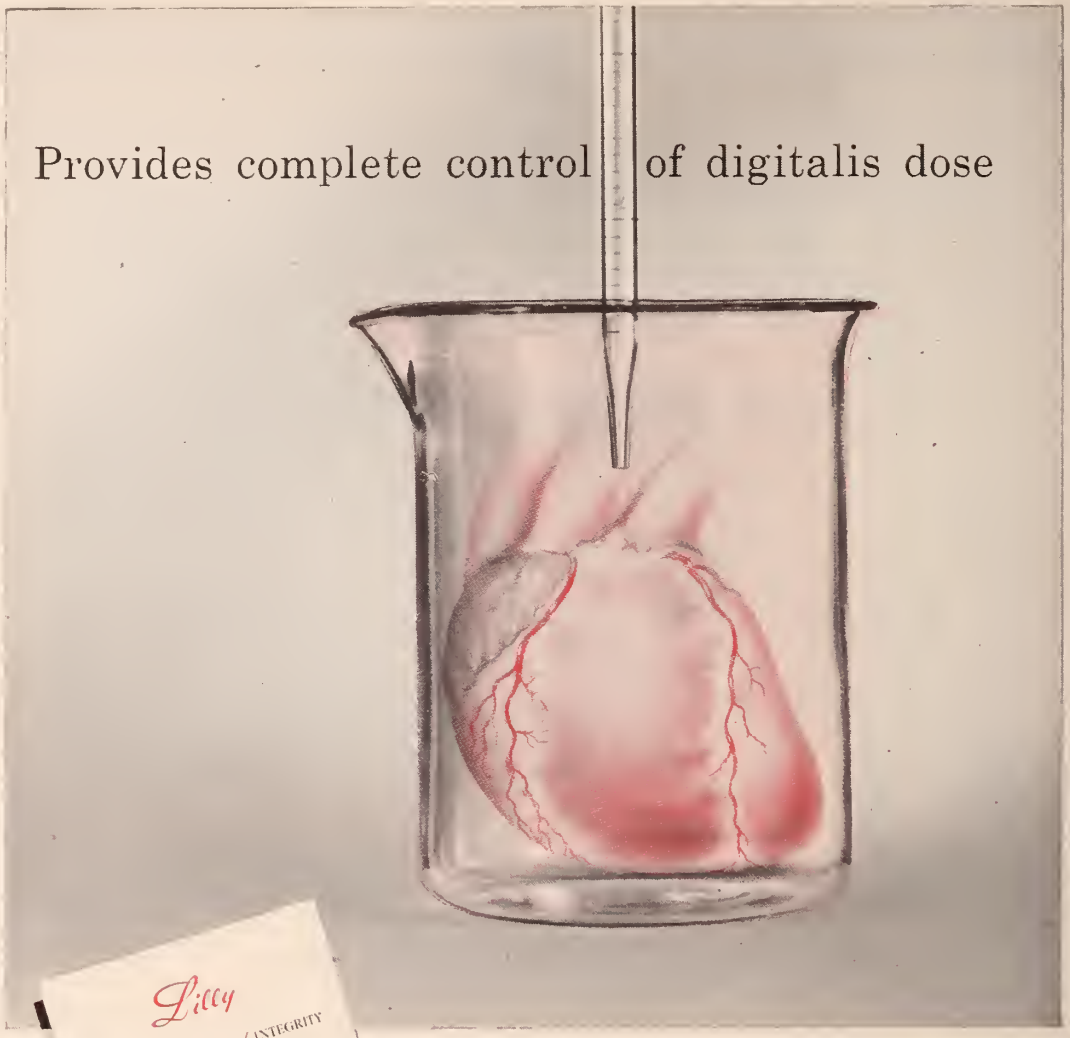
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80TH ANNIVERSARY 1876 • 1956

THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

All at Once it's May

All at once it's May. You want a little rest and relaxation and change. And your spring cleaning at home ought to be balanced by some mental spring cleaning too—by a chance to find out what's new in medicine. And then there is the periodic nostalgia of seeing old friends, old class-mates, former colleagues again.

You can do all this at once, right in the middle of May. You can get some painless postgraduate education. You can hear what's new at the section meetings. You can see what's new at the exhibits. You can assuage the sore eyes by the sight of the man you interned with, or your old class-mate, or one of the fraternity brethren. You can get away from tyranny of the telephone. You can have your say about medical politics, medical economics, medical administrations. You can rest, drink in some of the sun's ultraviolet rays, relax, and pad that nose so it will more comfortably fit the grindstone.

All this you can do. Where? How?

Simple. At the Annual Meeting in Atlantic City. Where else can you get so much that is both amusing and edifying in a few short days? No where else.

Why wait? Do it now. The 1956 Annual Meeting will never come again.

PUBLISHED MONTHLY SINCE 1904
Under the Direction of the Committee on Publication
J. LAWRENCE EVANS, JR., M.D., *Chairman*

HENRY A. DAVIDSON, M.D., Editor
MIRIAM N. ARMSTRONG, Assistant Editor

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Whole Number of Issues 621

VOL. 53, NO. 5 MAY, 1956 Subscriptions, $3.00 per Year
Single Copies, 30 Cents

Watson B. Morris, M.D., 1878-1956

The passing of Watson Morris symbolizes the end of an era. He was President of our Society in 1940, a period of major transition for organized medicine. Dr. Morris was born in Utica, N. Y., descended from Colonial ancestors, one of whom was Gouverneur Morris. He was graduated from Bellevue in 1902 and won one of the coveted Bellevue internships. In 1904 he undertook to serve as the personal physician to a travel-minded New Yorker and in that capacity sailed around the world on a private yacht. He was in the famous trans-Atlantic yacht race for the Kaiser Wilhelm cup in 1906. The ship was lost in a storm and when they finally returned to New York they found that their obituaries had already been published. Dr. Morris, however, was pretty durable. He was to last fifty more years.

In 1906 he joined hands with a senior surgeon and opened a small hospital in South Orange. Four years later he moved to the then rural village of Springfield, whose people he was to serve for over forty years. In Springfield Dr. Morris was active in civic affairs of all sorts, including service as president of a bank, an officer of the town medical society, president of the Union County Medical Society, president of the Board of Governors of the Union County Tuberculosis Hospital, and many others.

He joined the staff of Overlook Hospital in 1913, and in 1952 was honored by that hospital with the title of "dean." He was for years the senior member of the staff and was chief of staff from 1946 to 1950.

Dr. Morris became a Trustee of our Society in 1936, and in 1938 began the climb up the presidential ladder, being installed as President on June 6, 1940. He was a life Fellow of the American College of Surgeons and state regent of the Association of American Physicians.

As President of our Medical Society he was active in promoting the Fall Clinical Conference, and established for many county societies the pattern of monthly symposia on special topics. He was also a pioneer in the development of the State Society Regional Conference pattern in the United States. He encouraged the development of inter-county meetings. He was particularly effective in building a good public relations program for The Medical Society of New Jersey. One of the most conspicuous achievements of his administration was the enactment of the statute which established the Medical-Surgical Plan.

Part of Dr. Morris' medical roots lay in the very early twentieth century. He started practice in the days before antitoxin, vitamins and antibiotics. He was thus a very real and very vital link between two eras.

He will be remembered as a competent administrator who knew how to compromise on method without compromising on principle; as a medical society official who knew how to cultivate good public relations without sacrificing dignity or status; and as a cultivated gentleman of the old school.

THE 190th ANNUAL MEETING
OF
THE MEDICAL SOCIETY OF NEW JERSEY
HADDON HALL, ATLANTIC CITY
May 12, 13, 14, 15 and 16, 1956

DAILY SCHEDULE

Saturday, May 12, 1956

9:30 a.m.—Board of Trustees
Bakewell Room, 1st Floor

12:00 noon—Registration Opens
Sun Porch, Lounge Floor

2:30 p.m.—House of Delegates
Viking Room, 13th Floor

4:00 p.m.—Open Forum for Membership Discussion on Medical Society Policies and Programs
Viking Room, 13th Floor

8:00 p.m.—Open Forum for Membership Discussion on Medical-Surgical Plan
Viking Room, 13th Floor

8:30 p.m.—Nominating Committee
Bakewell Room, 1st Floor

Sunday, May 13, 1956

11:00 a.m.—Reference Committees:
"A"
Room 1333, 13th Floor
"B"
Room 1344, 13th Floor
"C"
Mandarin Room, 13th Floor
"D"
Room 1335, 13th Floor
"E"
Room 1337, 13th Floor
Constitution and By-Laws
Bakewell Room, 1st Floor
Miscellaneous Business
Rowsley Room, 1st Floor
Resolutions and Memorials
Room 1332, 13th Floor

4:00 p.m.—House of Delegates (election)
Viking Room, 13th Floor

8:00 p.m.—Civil Defense Symposium
Viking Room, 13th Floor

Monday, May 14, 1956

9:00 a.m.—Exhibits Open
Lounge Floor

10:00 a.m.—House of Delegates
Viking Room, 13th Floor

12:30 p.m.—Luncheon: Section on Surgery and New Jersey Chapter, American College of Surgeons
West Room, 13th Floor

2:00 p.m.—General Session on Surgery
Viking Room, 13th Floor

8:30 p.m.—General Session
Viking Room, 13th Floor

Tuesday, May 15, 1956

9:00 p.m.—Board of Trustees
Bakewell Room, 1st Floor

9:30 a.m.—Sections:
Allergy
Room 1344, 13th Floor
Anesthesiology
Rowsley Room, 1st Floor

10:00 a.m.—Sections:
Cardiovascular Diseases
Tower Room, 13th Floor
Clinical Pathology
Mandarin Room, 13th Floor
Ophthalmology
Card Room, Lobby Floor
Orthopedic Surgery
Viking Room, 13th Floor
Rheumatism
West Room, 13th Floor

12:30 p.m.—Luncheons:
New Jersey Allergy Society
Zodiac B, Chalfonte
Section on Anesthesiology
Zodiac A, Chalfonte
Section on Ophthalmology and New Jersey Ophthalmological Society
Blue Room, Chalfonte
Section on Orthopedic Surgery and New Jersey Orthopaedic Society
Roberts Room, Chalfonte
Section on Rheumatism
Bakewell Room, 1st Floor
Scientific Program Committee, New Jersey Heart Association
Room 1332, 13th Floor

2:00 p.m.—General Session on Obstetrics and Gynecology
Viking Room, 13th Floor

4:30 p.m.—New Jersey Ophthalmological Society
Mandarin Room, 13th Floor

7:00 p.m.—Dinner-Dance
Vernon Room, Lounge Floor

Wednesday, May 16, 1956

9:30 a.m.—Sections:
- Chest Diseases
  Rutland Room, 1st Floor
- Gastroenterology and Proctology
  West Room, 13th Floor
- Metabolism
  Vaux Hall, Chalfonte
- Neuropsychiatry
  Mandarin Room, 13th Floor
- Pediatrics
  Viking Room, 13th Floor

10:00 a.m.—Sections:
- Dermatology
  Marine Room, Chalfonte
- General Practice
  Tower Room, 13th Floor
- Otolaryngology
  Card Room, Lobby Floor
- Urology
  Room 1344, 13th Floor

12:30 p.m.—Luncheons:
- New Jersey Chapter, American College of Chest Physicians
  Wedgwood Room II, Lounge Floor
- Section on Dermatology and New Jersey Dermatological Society
  Bakewell Room, 1st Floor
- Section on General Practice and New Jersey Academy of General Practice
  Zodiac B, Chalfonte
- Section on Metabolism and Medical Members of New Jersey Diabetes Association
  Zodiac A, Chalfonte
- Section on Neuropsychiatry
  Roberts Room, Chalfonte
- Radiological Society of New Jersey
  Blue Room, Chalfonte

1:45 p.m.—Board of Directors, New Jersey Academy of General Practice
Zodiac B, Chalfonte

2:00 p.m.—General Session on Medicine
Viking Room, 13th Floor

3:00 p.m.—Exhibits Close
Lounge Floor

4:00 p.m.—Registration Closes
Sun Porch, Lounge Floor

CIVIL DEFENSE SYMPOSIUM

Sunday Evening, May 13, 1956

Viking Room, 13th Floor

Theme: Disaster Medicine

8:00 p. m.

Early Care of the Severely Injured by the Civilian Physician

The Problem of Mass Casualty Management
Joseph D. Goldstein, Lt. Col., M.C., Assistant Chief, Department of Atomic Casualties Studies, Walter Reed Army Institute of Research, Walter Reed Medical Center, Washington, D.C.

Surgical Principles in the Management of Trauma During Disaster
Joseph R. Shaeffer, Col., M.C., Chief Surgical Consultant, Office of the Surgeon General, Department of The Army, Washington, D.C.

Emergency Treatment of Fractures
Oscar P. Hampton, Jr., M.D., Member, Subcommittee on Trauma, American College of Surgeons, and Consultant to the Surgeon General, St. Louis, Mo.

General Discussion

9:10 p. m.

The United States Public Health Service Civil Defense Training Program
L. E. Burney, M.D., Assistant Surgeon General, United States Public Health Service, Washington, D.C.

9:30 p. m.

Planning for Disaster in New Jersey — Panel Discussion

Moderator: Elton W. Lance, M.D., Immediate Past-President, Rahway

Guest: Thomas S. Dignan, Acting Director, Division of Civil Defense-Disaster Control, New Jersey State Department of Defense, Trenton

Panel: Members of the Special Committee on Emergency Medical Service, Civil Defense

R. Winfield Betts, M.D., Chairman, Medford

David B. Allman, M.D., Atlantic City
G. Albin Liva, M.D., Wyckoff
Andrew F. McBride, M.D., Paterson
John L. Olpp, M.D., Englewood
Andrew C. Ruoff, M.D., Union City
Gerald Sinnott, M.D., Jersey City

GENERAL SESSION

MONDAY EVENING, MAY 14, 1956

8:30 p. m.

Viking Room, 13th Floor

Presiding: Vincent P. Butler, M.D., President

National Anthem

Inaugural Address
Lewis C. Fritts, M.D., President-Elect

Musical Selections
Joseph Stern's String Trio

TOWN MEETING OF THE AIR (ABC Radio Network)

Timely topic of interest to medicine and of national concern

An open meeting for all members of the Society and the Woman's Auxiliary.

DINNER-DANCE

TUESDAY EVENING, MAY 15, 1956

7:00 p. m.

Vernon Room, Lounge Floor

honoring

PRESIDENT AND MRS. VINCENT P. BUTLER

Toastmaster
Joseph P. Donnelly, M.D.

Welcome
Mrs. Andrew C. Ruoff, President, Woman's Auxiliary

Introductions
Mrs. Bertram J. L. Sauerbrunn, President-Elect, Woman's Auxiliary
Lewis C. Fritts, M.D., President-Elect

Presentation of Fellow's Key
To: Vincent P. Butler, M.D., President
By: Elton W. Lance, M.D., Immediate Past-President

UNDERGRADUATE MEDICAL EDUCATION TODAY AND THE PRACTICE OF MEDICINE; THE FACTORS INVOLVED IN THE DEVELOPMENT OF A NEW MEDICAL SCHOOL

Charles L. Brown, M.D., Dean, Seton Hall College of Medicine, Jersey City

Entertainment
The Carlyles—Singing Duo
Ruth Daye—Xylophone Virtuoso and Novelty Musical Act

Music
Joseph Stern's Orchestra

SCIENTIFIC SESSIONS

MONDAY AFTERNOON, MAY 14, 1956

GENERAL SESSION ON SURGERY

SALVATORE GIORDANO, M.D., Chairman, Morristown
G. RUFFIN STAMPS, M.D., Secretary, Atlantic City

12:30 p. m.

Luncheon—Section on Surgery and New Jersey Chapter, American College of Surgeons

West Room, 13th Floor

Scientific Session, Viking Room, 13th Floor

2:00 p. m.

Upper G. I. Bleeding, A Rational Approach

Stuart Z. Hawkes, M.D., Attending Surgeon, Presbyterian Hospital, Newark and
James D. Allan, M.D., Senior Resident in Surgery, Martland Medical Center, Newark

Discussor: Paul Mecray, Jr., M.D., Camden

In the last ten years, radical revision in the treatment of upper gastrointestinal bleeding has occurred. This paper discusses the trend away from medical management to surgical treatment. It defines and differentiates massive bleeding and lists indications for surgical intervention.

Some 150 cases at the Martland Medical Center, Newark, have been studied. These demonstrate selection of cases, types of treatment and pitfalls which may be encountered. An outline is offered for the handling of upper massive gastrointestinal bleeding, based on the literature of the last ten years and the experience of the authors in handling this problem.

2:30 p. m.

Use of Commercial Dacron Fabric in the Repair of Inguinal Hernias and Abdominal Wall Defects

James T. Wolstenholme, M.D., Staff Surgeon, Veterans Administration Hospital, East Orange

Discussor: Albert K. Levy, M.D., East Orange

In many inguinal hernias and abdominal wall surgery, deficiency of natural fascial layers often necessitates the use of a prosthesis, such as fascia lata, Surgaloy mesh, Tantalum mesh, or Fortisan to achieve a suitable repair of the defect. The authors have utilized commercial Dacron fabric in the repair of twelve inguinal hernias and two abdominal wall defects with encouraging results.

Dacron fabric appears to be a satisfactory prosthesis for the replacement of fascial layers since it is easily tailored, sutured without difficulty, well tolerated by the tissues and can always be readily available. The tissue reaction to Dacron is of a fibroblastic nature.

This paper is a preliminary report. A short movie in color is shown illustrating the technic in the use of Dacron fabric. Results of the implantation of Dacron fabric in rabbits are emphasized.

3:00 p. m.

Surgical Management of Diaphragmatic Hernia

John L. Madden, M.D., Director of Surgery, St. Clare's Hospital, New York, N. Y.

In this presentation, the anatomy of the muscular hiatus of the diaphragm for the esophagus is discussed and a technic for the transthoracic repair of a sliding hernia of the esophageal hiatus is illustrated. A dissection of the esophageal hiatus was performed in 20 fresh cadaver specimens. In all but one instance the hiatus was formed solely and completely by the right crus of the diaphragm. Accordingly, in the repair of an esophageal hiatal hernia one approximates not the right and left crura but the margins of the right crus. Choice of surgical approach, whether transabdominal or transthoracic, is predicated upon the findings in individual patients and the preference of the surgeon. In general, the transthoracic route is preferred.

3:30 p. m.

Some Factors Influencing Mortality and Morbidity in Perforated Peptic Ulcer

Peter J. Guthorn, M.D., Asbury Park, Associate Attending Surgeon, Monmouth Memorial Hospital, Long Branch

Discussor: Earle DeW. Stage, M.D., Morristown

In this study of 165 cases of perforated peptic ulcer over a 20 year period, age and duration of perforation were the most important factors influencing mortality. A notable clinical factor has been the increase among women. The surgical approach has not altered markedly but mortality has declined from 44 to 5 per cent. This has been due to the use of sulfonamides and antibiotics and, recognition of importance of fluid-electrolyte balance, blood transfusion, gastric suction and abandonment of intraperitoneal drainage.

4:00 p. m.

Business Session

4:15 p. m.

Five-Year Evaluation of Cardiac Arrest in The Presbyterian Hospital of Newark, N. J.

Gene L. D'Alessandro, M.D., Chief Anesthetist, The Presbyterian Hospital, Newark

Discussor: George N. J. Sommer, Jr., M.D., Trenton

ALLERGY

RALPH I. ALFORD, M.D., Chairman, Montclair
HERBERT W. DIEFENDORF, M.D., Secretary, Summit
Room 1344, 13th Floor

9:30 a. m.

Practical Considerations in Feeding Allergic Children

Joseph R. Jehl, M.D., Clifton, Attending Pediatrician, St. Joseph's Hospital, Paterson

This paper describes the author's experiences in feeding children, particularly infants, who are unable to take cow's and goat's milk in any of their modifications without allergic reactions and whose symptoms are not noticeably relieved with soy bean preparations. The author reviews the preparation of mixtures of "solid foods" which may be administered through a nipple to infants. There is also a discussion of how they grew and developed.

10:00 a. m.

Hay Fever

Isador Ripps, M.D., Clinical Assistant, Muhlenberg Hospital, Plainfield

Although pollen, particularly ragweed pollen, is the greatest cause of hay fever, seasonal and post-seasonal hay fever symptoms may also be produced by other agents. These factors are reviewed and their relationship to diagnosis and therapy discussed. Possible causes for failure in therapy are considered. Specific therapy, the use of inhibitors and the present status of non-specific therapy are reviewed. The importance of obtaining a purified pollen antigen and basic research to elucidate the biochemical mechanism of the allergic reaction is also stressed.

10:30 a. m.

Recent Advances in the Treatment of Allergic Diseases

Louis Tuft, M.D., Clinical Professor of Medicine, Temple University School of Medicine, Philadelphia, Pa.

Allergy to drugs, especially penicillin, now is of major interest to physicians because of the universal use of "specifics" and the rising tide of severe and sometimes fatal reactions. The author points out methods of recognizing drug allergy, including an evaluation of skin test methods. He reviews the means of preventing and treating reactions. Special attention is paid to the use of the cortico-steroids, not only in these situations but also in the treatment of asthma and related allergic diseases. The indications and value of these drugs are pointed out.

11:00 a. m.

The Use of Prednisone and Prednisolone in Refractory Cases of Pollinosis

Eugene J. Luippold, M.D., Boonton, Attending Physician, St. Clare's Hospital, Denville

11:30 a. m.

General Discussion

11:40 a. m.

Business Session

12:30 p. m.

Luncheon—New Jersey Allergy Society
Zodiac B, Chalfonte

ANESTHESIOLOGY

MILDRED T. BOHNE, M.D., Chairman, Summit
LESTER W. NETZ, M.D., Secretary, Hackensack

Rowsley Room, 1st Floor

9:30 a. m.

Neraval® — A New Induction Anesthetic — ECG Studies During and Following Induction

Irving M. Riffin, M.D., Attending Anesthesiologist, St. Vincent's Hospital, Montclair
Max Block, M.D., Attending in Medicine, Mountainside Hospital, Montclair

Several investigators in the past have studied the cardiovascular effects of the barbiturate anesthetic agents intravenously. This study is limited to electro-cardiographic changes during the rapid injection of Neraval® and for two minutes following its administration. As previously demonstrated, the changes are minimal and not clinically significant, if hypoxia and hypercarbia are not associated with the administration of the drug.

9:50 a. m.

Use of Neraval® in General Surgery

Marcel A. Mersch, M.D., Englewood, Attending Anesthesiologist, Holy Name Hospital, Teaneck

This is a discussion of a number of surgical cases in which Neraval® (methitural) was used as an anesthetic agent. The author describes the types and technics of anesthesiologic administration of this new agent. A summary of results and conclusions is presented.

10:10 a. m.

Discussion of first two papers

Irving R. Hayman, M.D., Paterson

10:20 a. m.

Lessons Learned from Operative Deaths Relating to Anesthesia

Edward T. Lawless, M.D., Attending Anesthesiologist, St. Joseph's Hospital, Paterson

Discussor: Robert K. Egge, M.D., East Orange

10:50 a. m.

Recess

11:00 a. m.

Medico-Legal Problems Relating to Anesthesiology

Mr. William G. Bischoff, Defense Attorney, U. S. F. & G., Camden

General Discussion and Question and Answer Period

11:45 a. m.

Business Session

12:30 p. m.

Luncheon—Section on Anesthesiology
Zodiac A, Chalfonte

CARDIOVASCULAR DISEASES

Robert B. Durham, M.D., Chairman, Atlantic City
Frank J. Brown, M.D., Secretary, Point Pleasant

Tower Room, 13th Floor

10:00 a. m.

Present Trend in the Office Management of the Hypertensive Patient

Henry C. Crossfield, M.D., West Orange, Consultant in Cardiology, Orange Memorial Hospital, Orange

General Discussion

A brief description of the anatomic nervous control of hypertension and an enumeration of the hormonal influences are given. The author then evaluates the effect of minute details of living and eating habits together with one's philosophy of life, on hypertension. This is followed by a discussion of some of the drugs most commonly used, their advantages and disadvantages. Future trends are forecast.

10:30 a. m.

Management of the Cardio-Hepatic Patient

Franklin M. Hanger, M.D., Professor of Medicine, Columbia University College of Physicians and Surgeons, New York, N. Y.

General Discussion

The parenchymal cells of the liver are readily injured by anoxia. Hepatic disturbances are common in acute and chronic cardiac failure, and present primary and secondary problems of great theoretical and therapeutic importance. Vascular derangements also develop during the course of many hepatic diseases and these may determine the clinical course.

11:15 a. m.

Management of Complications of Myocardial Infarction

Edward C. Klein, Jr., M.D., South Orange, Consultant in Cardiology, Hospital of St. Barnabas, Newark

General Discussion

Acute myocardial infarction caused by coronary thrombosis is readily diagnosed, but its treatment is for the most part symptomatic. The complications can tax the ingenuity and skill of the expert. Shock may be profound and it needs immediate attention. Congestive heart failure requires the usual treatment with low sodium diet, mercurial diuretics and digitalis. In the management of the cardiac arrhythmias, quinidine is the drug of choice, although, in some instances, pronestyl may be desirable. The thromboembolic phenomena require early use of anticoagulant therapy. This procedure, however, should not be routine unless the physician in charge is skilled in the technic and proper laboratory facilities are available. The indications and contraindications for anticoagulants along with the choice of drugs and dose schedule are discussed. Ten complications are presented.

11:45 a. m.

Business Session

CLINICAL PATHOLOGY

William T. Read, Jr., M.D., Chairman, Camden
George L. Erdman, M.D., Secretary, Summit

Mandarin Room, 13th Floor

10:00 a. m.

The Mycoses

Emma S. Moss, M.D., Director, Department of Pathology, Charity Hospital of Louisiana at New Orleans

Question and Answer Period

Fungous infections are recognized with greater frequency due to an increasing awareness of their occurrence and protean manifestations. They must be differentiated from tuberculosis, other granulomas, tumors and from each other, for therapy to be most effective.

Use of versatile antibiotics has resulted in fatal cases of moniliasis. Blastomycosis, histoplasmosis, and coccidioidomycosis were long thought to be rare, unusual and invariably fatal. Mass skin testing has indicated that large numbers of people have been infected by the species of fungi causing these diseases without having been aware of the infection.

Medically important species of fungi fall into three broad classes depending upon the type of infection most frequently produced; systemic, intermediate or superficial.

10:30 a. m.

Symposium on Mycoses

Moderator: Emma S. Moss, M.D.

Role of the Non-Pathogenic Fungi

Nathan Schaffer, M.D., Chief of Allergy Department, East Orange General Hospital, East Orange

The Surgical Aspects of Mycotic Infections

Anthony D. Crecca, M.D., Attending in Thoracic Surgery, St. Michael's Hospital, Newark

Dermatological Aspects of Mycotic Infections

Frederick C. Licks, M.D., South Orange, Attending Dermatologist, East Orange General Hospital, East Orange

Tissue Reactions to Mycotic Infections

Robert Breckenridge, M.D., Glenside, Pa., Director of Clinical Laboratories, Our Lady of Lourdes Hospital, Camden

Question and Answer Period
Questions to be submitted in writing from the floor.

11:50 a. m.

Business Session

OPHTHALMOLOGY

Joseph R. Weintrob, M.D., Chairman, Atlantic City
John Scillieri, M.D., Secretary, Paterson

Card Room, Lobby Floor

10:00 a. m.

Heterochromic Cyclitis

Emanuel P. Rosen, M.D., Surgeon, Newark Eye and Ear Infirmary, Newark

Heterochromic cyclitis was first completely described 50 years ago. Its history falls into two 25-year periods: (a) the preslitlamp-tuberculous era, and (b) the bio-microscopic era. Heterochromic cyclitis is more commonly reported in Europe. Probably it occurs just as frequently in this country, but apparently it is not as readily recognized. Some bio-microscopic signs are pointed out—along with gonioscopic findings and the important Amsler-Verray test is described. The relationship of heterochromia to the status dyscraphicus is described and the occurrence of heterochromia in the "glaucomato-cyclic" syndrome as well as in certain hypersensitivities is mentioned.

10:30 a. m.

Surgical Diseases of the Cornea, Keratoconus

Herbert M. Katzin, M.D., Director of Laboratory, Eye Bank for Sight Restoration, New York, N. Y.

11:00 a. m.

Recent Advances in the Treatment of External Diseases

Irving H. Leopold, M.D., Professor of Ophthalmology and Head of Department, Graduate School of Medicine, University of Pennsylvania, Philadelphia, Pa.

Since the introduction of steroids, several new derivatives have been made available for experimental and clinical therapy in eye diseases. These include hydrocortisone T butyl acetate, 9 alpha fluoro hydrocortisone, prednisone and prednisolone in addition to their forerunners, namely cortisone and hydrocortisone and ACTH. There are some differences in the activities of these compounds.

Ophthalmologists should pay attention to antibiotics, such as neomycin, bacitracin, polymisin and the chemotherapeutic agents such as furacin, sodium propionate and various sulfonamides. The antibiotics which should be employed for local administration are those which are not likely to be used in a wide-scale for systemic administration. In this way, the patient will not have lost a great deal if he develops sensitivity to the local use of steroids and to the local use of antibiotics. The ophthalmologist should not neglect chemical agents which are valuable for external diseases and have stood the test of time in preference for newer drugs which may not prove, in the long run, to be superior.

11:30 a. m.

General Discussion from the floor

11:45 a. m.

Business Session

12:30 p. m.

Luncheon—Section on Ophthalmology and New Jersey Ophthalmological Society

Blue Room, Chalfonte

ORTHOPEDIC SURGERY

OTTO LEHMANN, M.D., Chairman, Long Branch

HAROLD T. HANSEN, M.D., Secretary, South Orange

Viking Room, 13th Floor

10:00 a. m.

Congenital Disorders of the Foot

Michael Taranto, M.D., Elizabeth, Attending Surgeon, New Jersey Orthopaedic Hospital, Orange

10:20 a. m.

Static Disorders of the Foot

Albert Willner, M.D., North Arlington, Associate in Orthopedics, West Hudson Hospital, Kearny

10:40 a. m.

General Discussion on first two papers

11:00 a. m.

The Menace of Anti-Arthritic Remedies

Harold Thomas Hyman, M.D., Author of "Integrated Practice of Medicine," Pipersville, Pa.

General Discussion

Some of the more crippling arthropathies, notably rheumatoid arthritis, are manifestations of hypersensitivity reactions, presumably to bacterial antigen. Similar lesions may be, and have been, produced in sensitized patients by the administration of therapeutic products, notably salicylates and sulfonamides. Since none of these anti-arthritic drugs has specific potential; and since it is not possible to tell, in advance, which patient will respond to them with a remote hypersensitivity syndrome, the conscientious practitioner re-appraises their indications.

11:40 a. m.

Business Session

12:30 p. m.

Luncheon—Section on Orthopedic Surgery and New Jersey Orthopaedic Society

Roberts Room, Chalfonte

RHEUMATISM

R. WINFIELD BETTS, M.D., Chairman, Medford

EVELYN Z. MERRICK, M.D., Secretary, Orange

West Room, 13th Floor

10:00 a. m.

Soft Tissue Distress in Rheumatic Disease

Peter J. Warter, M.D., Head, Department of Medicine, and Chief of Rheumatology, McKinley Memorial Hospital, Trenton

The distress from soft tissue changes in rheumatic diseases presents many challenging diagnostic and therapeutic problems. Fibrositis is the most frequent soft tissue illness. This condition has been the "scrap barrel" of rheumatic distress, for many years.

Treatment should be directed toward the correction of emotional instabilities and their causes. Only then can drugs and rehabilitative procedures be of value.

10:20 a. m.

Current Status of Corticosteroids in Collagen Disease

Robert W. Burlew, M.D., Senior Physician, Research Staff, Schering Corporation, Bloomfield

The author offers a brief summary of clinical reports accumulated during the experimental evaluation of Meticorten® and Meticortelone® in rheumatoid arthritis, rheumatic fever, disseminated lupus erythematosus, periarteritis nodosa, dermatomyositis, and scleroderma.

10:40 a. m.

An Interpretation of the Basic Mechanism Which Would Explain the Signs, Symptoms, and Natural History of Rheumatoid Disease

Thomas McPherson Brown, M.D., Professor of Medicine, George Washington School of Medicine, Washington, D. C.

11:05 a. m.

Therapy of the Arthritides—Panel Discussion

Moderator: John W. Gray, M.D., Consultant in Arthritis, St. Barnabas Hospital, Newark

Panel: Rheumatologists

Herman H. Tillis, M.D., Associate in Arthritis, Presbyterian Hospital, Newark

William D. Kimler, M.D., Haddon Heights, Assistant in Rheumatology, Cooper Hospital, Camden

TUESDAY MORNING, MAY 15, 1956

Orthopedist

E. Vernon Davis, M.D., Associate Orthopedic Surgeon, Cooper Hospital, Camden

Physiatrist

Bertram M. Bernstein, M.D., Chief, Department of Physical Medicine and Rehabilitation, McKinley Memorial Hospital, Trenton

This is a panel discussion of the treatment of actively progressive Stage II rheumatoid arthritis patients. It includes consideration of gouty arthritis in (a) an acute attack and (b) interim therapy. It discusses corrective measures for ankylosis of hip and knee joints. The value of traction in the treatment of cervical osteoarthritis with or without the arm syndrome will be reviewed.

11:30 a. m.

Business Session

12:30 p. m.

Luncheon—Section on Rheumatism
Bakewell Room, 1st Floor

TUESDAY AFTERNOON, MAY 15, 1956

OBSTETRICS AND GYNECOLOGY

Felix H. Vann, M.D., Chairman, Englewood

Stanton H. Davis, M.D., Secretary, Plainfield

Viking Room, 13th Floor

2:00 p. m.

Joint Meeting with the Committee on Maternal and Infant Welfare

Lessons From Maternal Deaths—Obstetrical Emergencies—Panel Discussion

Moderator: John D. Preece, M.D., Chairman, Committee on Maternal and Infant Welfare, Trenton

Panel: D. Anthony D'Esopo, M.D., Professor of Clinical Obstetrics and Gynecology, Columbia University College of Physicians and Surgeons, New York, N. Y.

Clayton T. Beecham, M.D., Clinical Professor of Obstetrics and Gynecology, Temple University School of Medicine, Philadelphia, Pa.

Robert A. MacKenzie, M.D., Asbury Park, Senior Attending Obstetrician, Monmouth Memorial Hospital, Long Branch

Edward G. Waters, M.D., Attending Obstetrician, Margaret Hague Maternity Hospital, Jersey City

Case Presentations and Panel Discussions:
Eclamptic Death
Death from Ruptured Uterus
Anesthetic Death
Ectopic Death

General Discussion and Questions from the floor

4:20 p. m.

Business Session

WEDNESDAY MORNING, MAY 16, 1956

CHEST DISEASES

Emanuel Klosk, M.D., Chairman, Newark

Wilbur F. Jehl, M.D., Secretary, North Caldwell

Rutland Room, 1st Floor

9:30 a. m.

Cytological Patterns in Bronchopulmonary Disease

A. Albert Carabelli, M.D., Attending in Thoracic Medicine, St. Francis Hospital, Trenton

Discussor: Milton H. Kannerstein, M.D., Newark

This is a study of the bronchial aspirate or irrigate in 1000 cases of bronchopulmonary disease. The Papanicolaou technic was used to determine pathognomonic cytograms. The study revealed three large categories of bronchopulomonary diseases which may be said to have a characteristic cytogram:

a. Acute and chronic suppurative bronchopneumonitis with the leukocyte prominent or predominating.

b. Acute and chronic allergic bronchopulmonary disease with eosinophiles present or prominent.

c. Neoplastic bronchopulmonary disease with malignant cells present.

The cytogram of acute or chronic suppurative disease may be superimposed on either the allergic or the neoplastic groups to mask the underlying disease.

A peculiar pseudo-malignant group of cells (easily mistaken for malignant epidermoid types) is present in the bronchopulmonary suppurative group and occasionally in the allergic group.

9:55 a. m.

A Survey of 900 Consecutive Cases of Myocardial Infarction

Irving L. Applebaum, M.D., Attending Physician in Medicine, Newark Beth Israel Hospital, Newark

Discussor: Norman Reitman, M.D., New Brunswick

This is a review of 888 cases of myocardial infarction at the Newark Beth Israel Hospital. It is noted that the disease is more common in males (3 to 1), occurred at earlier age in males, seemed relatively more common in individuals of Hebrew faith and less common in the Negro. Past medical history reveals an incidence of 46 per cent angina pectoris, 25 per cent previous myocardial infarction, 22 per cent hypertension and 14 per cent diabetes mellitus. The "silent" attack is unusual. The course of disease and laboratory data (including an analysis of post-mortems) are discussed with particular emphasis on congestive heart failure, shock and complications, including thromboembolism. Electrocardiographic findings are reviewed. Therapy, especially anticoagulants, is discussed and the efficacy of Dicumarol® is questioned.

10:20 a. m.

An Analysis of 100 Cases of Tuberculosis Treated at Home

Benjamin P. Potter, M.D., Consultant in Chest Diseases, St. Francis Hospital, Jersey City

Discussor: Joseph A. Smith, M.D., Glen Gardner

Home treatment of tuberculosis has been extended to larger groups of patients since the advent of the anti-tuberculous drugs. Whether time will prove it superior, as good as or inferior to hospital management remains to be seen, but there are certainly some definite contraindications. The author answers these questions from his experience in the 100 cases to be presented. The follow-up on these completed cases is from one to five years. Many of these patients have had one or more admissions to tuberculous hospitals for deactivation of their tuberculosis prior to starting the home treatment.

10:45 a. m.

Trauma to the Chest

Ross J. Simpson, M.D., Bayonne, Attending Surgeon, B. S. Pollak Hospital for Chest Diseases, Jersey City

Discussor: Lawrence Gilbert, M.D., Newark

11:10 a. m.

Serial Tomography in the Chemotherapeutic Management of Pulmonary Tuberculosis

Irving J. Selikoff, M.D., Associate in Medicine, Barnert Memorial Hospital, Paterson

Co-Authors: David Roth, M.D., Paterson
Robert H. Joelson, M.D., Paterson

Discussor: Paul K. Bornstein, M.D., Asbury Park

11:35 a. m.

Business Session

12:30 p. m.

Luncheon—New Jersey Chapter, American College of Chest Physicians

Wedgwood Room II, Lounge Floor

DERMATOLOGY

Cedric C. Carpenter, M.D., Chairman, Summit
Herman Kline, M.D., Secretary, Atlantic City

Marine Room, Chalfonte

10:00 a. m.

A Recapitulation of Local Antibiotic Therapy

Milton B. Sloane, M.D., Englewood, Director, Department of Dermatology, Bergen Pines County Hospital, Paramus

The author speculates about future trends in antibiotic and chemotherapy, and on the possibility of using benzimidazole derivatives in the chemotherapy of viral diseases. Comparison is made of the local efficacies of the existing antibiotics: the organisms against which they are effective and the relative index of sensitization. The new antifungal antibiotics appear to hold such great possibilities for the future that one of them, Nystatin®, will be a follow-up of the preliminary work reported in Dr. Sloane's paper in the *Journal of Investigative Dermatology*, last June. Its greatest usefulness appears to be in moniliasis, and the problem is discussed. The shortcomings, as well as the usefulness of Nystatin® are brought in, and what results may be expected. Some unusual forms of moniliasis will be displayed.

10:25 a. m.

Seborrheic Dermatitis—Evaluation of Therapy

Sam C. Atkinson, M.D., Associate Attending Dermatologist, Overlook Hospital, Summit; and

Cedric C. Carpenter, M.D., Attending Dermatologist, Overlook Hospital, Summit

The literature is reviewed regarding therapy of seborrheic dermatitis. Newer drugs, such as sodium sulfacetamide, tranquilizing drugs, and anti-

biotics are briefly discussed and compared with older medications (sulfur, mercury, and vioform). Internal medications are considered an important adjunct to therapy: vitamin B complex, liver extract injections, and vitamin B_{12} have been found to be valuable. Two hundred and sixty-four patients were followed and the results of various treatments analyzed by means of charts: local, internal, and physical therapeutic methods were considered separately.

10:45 a. m.

Consideration of Causes of Seborrheic Dermatitis

Henry B. Decker, M.D., Camden, Professor of Dermatology, Jefferson Medical College, Philadelphia, Pa.

11:10 a. m.

Business Session

11:25 a. m.

Treatment of Cancer of the Skin

Richard L. Sutton, Jr., M.D., Kansas City, Mo., Chairman, Department of Dermatology, University of Kansas Medical Center

"Cancer of the skin" is limited in this discussion to discrete epithelial neoplasms, basal and squamous cell carcinomas in particular, and the precursor lesions that evolve into them. Recognition of the small, early lesion is not difficult. The necessity will be stressed for adequacy of the measures used for destroying these tumors. The technic of, and reasons for, adequacy of therapy will be described, with clinical and histologic illustrations. It is erroneous to attack skin cancer centrifugally. Sacrifice of normal tissue peripheral to tumor tissue is necessary, whether treatment be surgical or radiologic. The methods used by Dr. Sutton are described.

12:30 p. m.

Luncheon—Section on Dermatology and New Jersey Dermatological Society
Bakewell Room, 1st Floor

GASTROENTEROLOGY AND PROCTOLOGY

Benjamin J. Macchia, M.D., Chairman, Jersey City
Abraham L. Reich, M.D., Secretary, Newark

West Room, 13th Floor

9:30 a. m.

The Modern Treatment of Portal Cirrhosis

Irving B. Brick, M.D., Associate Professor of Medicine and Chief of Gastroenterology Clinic, Georgetown University School of Medicine, Washington, D. C.

Discussor: Ferdinand G. Weisbrod, M.D., East Orange

10:00 a. m.

Symposium on Non-Specific Ulcerative Colitis

Medical Aspects

Samuel M. Gilbert, M.D., Adjunct in Medicine, Beth Israel Hospital, Newark

Non-specific ulcerative colitis is a serious disease of young adults. Early diagnosis is stressed so that thorough medical treatment may be instituted before the disease has progressed from the rectum. Adequate medical therapy can control 75 per cent of cases.

Radiological Aspects

Leo H. Siegel, M.D., Attending in Gastroenterology, Presbyterian Hospital, Newark

The general radiologic characteristics of nonspecific ulcerative colitis are well documented and are dealt with only briefly. Of increasing interest is the lack of correlation betwen the gravity of disease (as manifested clinically) and to the x-ray findings as interpreted by the usual standards. Cases will illustrate serious disease with minimal roentgenologic findings and relatively mild clinical disease with apparently severe x-ray findings. A number of cases of rather unusual degree of improvement following accepted therapy are shown.

The conclusion is that the clinical picture, including sigmoidoscopic findings, is the keystone of prognosis with little reliance to be placed on the roentgenologic findings except for localization.

Surgical Aspects

Earl J. Halligan, M.D., Medical Director, Medical Center, Jersey City

Surgery does not eliminate the cause of ulcerative colitis, but it does remove the pathologically involved tissue. The price of surgery is the excision of the colon and rectum with the establishment of a permanent ileostomy. Therefore, indications for surgery must be carefully considered. Ileostomy itself is not without its complications, such as obstruction, fistula, loss of fluid and electrolytes often endangering life, prolapse or retraction of the ileostomy, secondary enteritis, et cetera. A one stage total colectomy with resection of the rectum and performance of the ileostomy at the same time is favored.

The discussion lists indications for operation, operative technic, reasons for preferring one stage operation, complications of ileostomy, their prevention and surgical treatment.

General Discussion

11:00 a. m.

Injection Treatment of Hemorrhoids — Present Day Concepts

Urban R. Finnerty, M.D., Director of Proctology, St. Vincent's Hospital, Montclair

General Discussion

11:30 a. m.

Business Session

GENERAL PRACTICE

LOUIS K. COLLINS, M.D., Chairman, Glassboro
CHARLES H. CALVIN, M.D., Secretary, Perth Amboy

Tower Room, 13th Floor

10:00 a. m.

Symposium on Proteinuria

The Clinical Significance of Proteinuria

Abraham Cantarow, M.D., Professor of Biochemistry, Jefferson Medical College of Philadelphia, Philadelphia, Pa.

Discussor: William W. Hersohn, M.D., Atlantic City

In evaluating the clinical significance of proteinuria, the following questions should be answered: (a) what is the protein? (b) where does it enter the urine? (c) is it present continually or intermittently and, if intermittently, under what circumstances does it appear? (d) how much protein is being excreted? The paper is directed towards answering these questions and clarifying their clinical significance.

The Lower Nephron Syndrome

John H. Hodges, M.D., Assistant Professor of Medicine, Jefferson Medical College of Philadelphia, Philadelphia, Pa.

Discussor: Thomas K. Rathmell, M.D., Trenton

The Toxemias of Pregnancy

Robert A. Cosgrove, M.D., Attending in Obstetrics, Margaret Hague Maternity Hospital, Jersey City

Discussor: Frederick J. Faux, M.D., Woodbury

Nephritis

Joseph I. Echikson, M.D., Attending in Medicine, Hospital of St. Barnabas, Newark

Discussor: Irvin Sussman, M.D., Bridgeton

This is a discussion of nephritis and nephrosis and the relationship between the two. Dr. Echikson reviews the causes, diagnosis, treatment and sequellae. Particular emphasis is given to the early recognition of these conditions so as to institute early and appropriate treatment to prevent the late disabling features of these diseases.

11:50 a. m.

Business Session

12:30 p. m.

Luncheon—Section on General Practice and New Jersey Academy of General Practice

Zodiac B, Chalfonte

METABOLISM

JAMES F. GLEASON, M.D., Chairman, Atlantic City
NORMAN L. MURRAY, M.D., Secretary, Summit

Vaux Hall, Chalfonte

9:30 a. m.

Radiologic Aspects of Metabolic Bone Disease

Daniel Wilner, M.D., Assistant Chief of Radiology, Atlantic City Hospital, Atlantic City

A number of metabolic disorders may produce abnormal changes in the skeletal system. Gout, renal osteodystrophy, renal rickets and the diseases of the reticulo-endothelial system with predominant lipoid metabolic changes, are considered in this category. Roentgen findings in each of these metabolic diseases are presented and interpreted.

10:00 a. m.

Clinical and Chemical Aspects of Metabolic Bone Disease

Alexander B. Gutman, M.D., Director of Medicine, Mt. Sinai Hospital, New York, N. Y.

The most pertinent chemical determinations in the differential diagnosis of metabolic bone diseases are estimation of serum calcium, inorganic phosphate and alkaline phosphatase. Factors regulating the blood level of these constituents are discussed, then the factors which effect abnormal levels, how they operate, and their significance in differential diagnosis. Special attention is given to newer concepts of the role of the parathyroid glands and of renal tubular functions.

Particular clinical problems relate to Paget's disease, osteomalacia, osteoporosis and sarcoidosis. Current questions as to etiology, diagnosis and management are considered.

10:30 a. m.

Evaluation of Adrenal Function Today

Abbie I. Knowlton, M.D., Assistant Professor of Medicine, Columbia University College of Physicians and Surgeons, New York, N. Y.

11:00 a. m.

The Early Course of Juvenile Diabetes Mellitus

Louis Grunt, M.D., Associate, Metabolic Service, Martland Medical Center, Newark

11:30 a. m.

Business Session

12:30 p. m.

Luncheon—Section on Metabolism and Medical Members, New Jersey Diabetes Association

Zodiac A, Chalfonte

NEUROPSYCHIATRY

WILLIAM FURST, M.D., Chairman, East Orange
HARRY H. BRUNT, M.D., Secretary, Hammonton

Mandarin Room, 13th Floor

9:30 a.m.

Symposium: Progress in Neurosurgery, Neurology, and Psychiatry

Progress in Neurosurgery

Richard D. Swain, M.D., Medical Director and Attending Neurosurgeon, Newark Eye & Ear Infirmary, Newark

Progress in Neurology

Israel S. Wechsler, M.D., Professor of Clinical Neurology, Columbia University College of Physicians and Surgeons, New York, N. Y.

A new and fruitful era has dawned for clinical neurology in recent years. Concepts have broadened for the understanding of the structure and function of the brain. The great neurologists of the past two generations laid the foundation of a scientific discipline by classifying disease syndromes of the nervous system. The new phase is rich in contributions which give insight into much that is still obscure in neurology and psychiatry, and is throwing light on many problems in internal medicine. Experimental neurophysiology, biochemistry and pharmacology are enriching clinical neurology.

Progress in Psychiatry

Nolan D. C. Lewis, M.D., Director of Research, New Jersey State Department of Institutions and Agencies

Dr. Lewis offers a review of recent trends to determine the causes, development and therapy of mental disorders. This is done in the light of the current realization of the magnitude of the problems presented by these conditions. These trends take a three directional course: (1) Increasing interest and action in basic research in several sciences that deal with human nature in its biochemical, physiologic and other constitutional aspects. (2) Research into interhuman relationships and any bearing they may have on the formation of symptoms and symptom patterns and (3) The study of societies and cultures in terms of impact and stress factors that may play predisposing or precipitating roles in the incidence of mental disorders.

11:45 a.m.

Business Session

12:30 p.m.

Luncheon—Section on Neuropsychiatry
Roberts Room, Chalfonte

OTOLARYNGOLOGY

BAXTER H. TIMBERLAKE, M.D., Chairman, Atlantic City

WARREN E. CRANE, M.D., Secretary, Trenton

Card Room, Lobby Floor

10:00 a.m.

Early Treatment of Head and Neck Injuries

Arthur W. von Deilen, M.D., Camden, Assistant Professor of Plastic Surgery, Graduate School of Medicine, University of Pennsylvania, Philadelphia, Pa.

General Discussion

Effort is made to stress the things that must be done soon after the accident. First, to preserve the patient's life and secondly, to put the patient's features in a condition where adequate future definitive repairs can be made.

10:35 a.m.

The Use and Abuse of Corticosteroids in Otolaryngology

Thomas F. Flynn, Jr., M.D., Associate Attending Otolaryngologist, Underwood Hospital, Woodbury

General Discussion

This paper deals with the uses of the adrenocortical steroids in the treatment of diseases seen by the otolaryngologist. Both internal and local uses are discussed. The abuses of these drugs are represented and discussed, especially in relation to local therapy. Some of the newer halogerated forms of steroids are listed and their role in otolaryngology mentioned.

11:00 a.m.

Carcinoma of the Larynx

Phillip H. Vonfraenkel, M.D., Associate Staff, Hahnemann Medical College and Hospital, Philadelphia, Pa.

General Discussion

11:40 a.m.

Business Session

PEDIATRICS

WALTER L. MITCHELL, JR., M.D., Chairman, Newark
JOSEPH F. RAFFETTO, M.D., Secretary, Asbury Park

Viking Room, 13th Floor

9:30 a. m.

The Changing Picture in Infectious Diseases

The Role of the Contagious Disease Hospital

Ellis L. Smith, M.D., Medical Director and Superintendent, Essex County Hospital, Belleville

The picture in infectious diseases is markedly improved. Hospitalization is necessary only occasionally. The "communicable disease" hospital is going out of business. The factors responsible for this are reviewed. These factors include immunization, better hygiene, prevention of complications and the antibiotics.

Public Health—Epidemiologic Aspects

Carl E. Weigele, M.D., Deputy Commissioner, New Jersey State Department of Health, Trenton

10:45 a. m.

Business Session

11:00 a. m.

Poliomyelitis

Lewis L. Coriell, M.D., Medical Director, Camden Municipal Hospital, Camden

Streptococcal Infections—Nephritis, Scarlet Fever, and Rheumatic Fever

Horace L. Hodes, M.D., Director, Department of Pediatrics, Mt. Sinai Hospital, New York, N. Y.

UROLOGY

EMMET J. CONNELL, M.D., Chairman, Jersey City
RALPH S. FERENCHAK, M.D., Secretary, Plainfield

Room 1344, 13th Floor

10:00 a. m.

Electrolyte and Fluid Balance in Urologic Disease

Anthony R. Fernicola, M.D., Chief of Urology, American Legion Hospital, Newark

10:20 a. m.

The Urologic Problem in Post-Poliomyelitic Respirator Cases

John J. O'Connor, Jr., M.D., Union City, Associate Attending Urologist, St. Mary's Hospital, Hoboken

The urologic problem in post-poliomyelitic respirator cases is primarly urinary tract calculus formation. Medical approaches for the prevention and control of calculi have been disappointing. The major problem remains the management of calculi already present. Conservative nonoperative therapy is discussed. The bulk of the paper deals with major urologic surgery in these patients discussing, through case presentations, the operative risk, tolerance to surgery, postoperative management, and postoperative complications.

10:40 a. m.

Primary Tumors of the Ureter

Francis P. Twinem, M.D., Director of Urology, Hackensack Hospital, Hackensack

Primary ureteral tumors are being found more often with a greater awareness on the part of urologists and better diagnostic methods. Twenty cases are reported—six classed as benign and fourteen as malignant. Follow-ups were obtained in all but one case. Diagnostic methods, treatment and results are discussed. The importance of considering the possibility of ureteral tumor in all cases of unexplained unilateral hydronephrosis is emphasized.

11:00 a. m.

The Johnson-Lowsley Operation for Urinary Diversion

Frank R. Begen, M.D., Cresskill, Associate Attending Urologist, Holy Name Hospital, Teaneck

A description of the Johnson-Lowsley operation for urinary diversion is given, illustrative slides are shown. The indications for and advantages of the operation, as compared to other methods of diversion are reviewed. Dr. Begen discusses the seven cases done in Holy Name Hospital with one detailed case presentation.

11:20 a. m.

Business Session

GENERAL SESSION ON MEDICINE

STEWART F. ALEXANDER, M.D., Chairman, Park Ridge
HERMAN H. TILLIS, M.D., Secretary, Newark

Viking Room, 13th Floor

2:00 p.m.

Gout in 1956

James W. Robinson, M.D., Assistant in Medicine, Overlook Hospital, Summit; and
Theodore R. Failmezger, M.D., Madison, Consultant in Medicine, All Souls Hospital, Morristown

Gout is an ancient-modern disease which will be seen with increasing frequency in the future because of the aging population. Isotopic labeling of basic aminoacids has greatly increased our knowledge of purine metabolism. Uric acid itself is probably not responsible for acute gout although it, of course, produces tophi in chronic gout. Colchicine is still our best weapon in the treatment of the acute attack. Butazolidin may also be useful; the steroids are frequently disappointing. The management of chronic tophaceous gout has been greatly facilitated by the use of the uricosuric agent Benemid.®

2:25 p.m.

Multiple Myeloma

Sidney Trubowitz, M.D., Assistant Chief, Medical Service, Veterans Administration Hospital, East Orange

This is a presentation of the important clinical features of myeloma as well as the x-ray and laboratory features with special emphasis on the cytology, cytochemistry of the plasma cell and of the abnormal protein synthesis characteristic of this disorder.

2:50 p.m.

Hazards in Antibiotic Therapy

Samuel B. Reich, M.D., Attending Physician, Hackensack Hospital, Hackensack

In today's treatment, the patient receives potent and often toxic or sensitizing drugs. Hypersensitivity to antibiotics demonstrates that the body is defeated by reaction to its own intrinsic intelligence. Bacteria, in their instinctive wisdom, survive antibiotics by developing resistance through shunting biochemical mechanisms. These jeopardies make it imperative that appropriate drugs be used on adequate indication for proper pathogens or diseases, and in proper doses and modes of administration.

3:15 p.m.

The Newer Corticosteroids

George Babcock, Jr., M.D., Associate Director, Division of Clinical Research, Schering Corporation, Bloomfield

3:40 p.m.

Business Session—All members are requested to remain and participate.

HOUSE OF DELEGATES

President, Vincent P. Butler, M.D., Jersey City
Secretary, Marcus H. Greifinger, M.D., Newark

The Committee on Credentials will meet at the Registration Desk each morning of the meeting.

Viking Room, 13th Floor

SESSIONS

First Session: 2:30 p.m., Saturday, May 12, 1956

1. Call to Order
2. Invocation
3. Organization of House of Delegates
4. Transactions of 1955 Annual Meeting
5. Introduction of Guests and Delegates from Other States
6. Annual and Supplemental Reports
7. New Business
8. Announcements

Second Session: 4:00 p.m., Sunday, May 13, 1956

1. Report of Nominating Committee
2. Election

Third Session: 10:00 a.m., Monday, May 14, 1956

1. Reports of Reference Committees
2. Unfinished Business
3. Installation of Incoming President
4. Adjournment

NOMINATING COMMITTEE

Saturday Evening, May 12, 1956

Chairman, Elton W. Lance, Immediate Past-President

8:30 p.m.

Bakewell Room, 1st Floor

County	*Delegate*	*Alternate*
Atlantic	David B. Allman	G. Ruffin Stamps
Bergen	G. Barton Barlow	Frederick G. Dilger
Burlington	E. Vernon Davis	R. Winfield Betts
Camden	Frank J. Hughes	Edmund C. Hessert
Cape May	Herschel Pettit	
Cumberland	Carl N. Ware	Mary Bacon
Essex	Marcus H. Greifinger	William W. Cox
Gloucester	Louis K. Collins	Baxter A. Livengood
Hudson	James F. Lynch	John J. Bedrick
Hunterdon	Lloyd A. Hamilton	Arthur M. Jenkins
Mercer	George A. Corio	Raymond A. McCormack, Jr.
Middlesex	John H. Rowland	Edward F. Klein
Monmouth	Daniel F. Featherston	Louis F. Albright
Morris	F. Clyde Bowers	Stanley Teskey
Ocean	Raymond A. Taylor	Abraham Goldstein
Passaic	Joseph R. Jehl	Sandor A. Levinsohn
Salem	C. Spencer Davison	Harry W. Fullerton, Jr.
Somerset	George E. Barbour	Runkle F. Hegeman
Sussex	Dorsett L. Spurgeon	Robert A. Weinstein
Union	Lorrimer Armstrong	Louis S. Wegryn
Warren	Ralph M. L. Buchanan	Frank J. Bartolini

REFERENCE COMMITTEES

Sunday Morning, May 13, 1956

11:00 a. m.

Reference Committee "A"

Room 1333, 13th Floor

Reports of the:

- President
- Board of Trustees
- Secretary
- Judicial Council
- Executive Officer

Reference Committee "B"

Room 1344, 13th Floor

Reports of the:

- Treasurer
- Finance and Budget Committee
- Publication Committee

Reference Committee "C"

Mandarin Room, 13th Floor

Reports of the:

- Medical Service Administration
- Medical-Surgical Plan

Reference Committee "D"

Room 1335, 13th Floor

Reports of the:

- Medical Education Committee
- Medical Defense and Insurance Committee
- Special Committees on:
  - Emergency Medical Service, Civil Defense
  - Physicians Placement Service
  - Widows and Orphans of Medical Men

Reference Committee "E"

Room 1337, 13th Floor

Reports of the:

Welfare Committee

Subcommittees on:

Legislation
Medical Practice
Public Health
Public Relations

Special Committees on:

Cancer Control
Chronically Ill
Conservation of Hearing and Speech
Conservation of Vision
Industrial Health
Maternal and Infant Welfare
Routine Health Examination
School Health
Workmen's Compensation

Reference Committee on Constitution and By-Laws

Bakewell Room, 1st Floor

To consider:

Amendments to the Constitution
Amendments to the By-Laws

Reference Committee on Miscellaneous Business

Rowsley Room, 1st Floor

Reports of the:

Annual Meeting Committee

Subcommittees on:

Scientific Program
Scientific Exhibit

Advisory Committee to the Woman's Auxiliary

Reference Committee on Resolutions and Memorials

Room 1332, 13th Floor

To consider:

Honorary Membership Committee Report
Nominations for Emeritus Membership
Resolutions
Memorials

Reference Committee on Credentials will meet at the Registration Desk each morning of the meeting.

Woman's Auxiliary
To The Medical Society of New Jersey

TWENTY-NINTH ANNUAL MEETING

DAILY SCHEDULE

SUNDAY, MAY 13, 1956

10:00 a.m.—Registration Opens
Sun Porch, Lounge Floor

6:30 p.m.—Fellowettes' Dinner
(For Fellowettes only)
Rowsley Room, 1st Floor

8:00 p.m.—Civil Defense Symposium of The Medical Society of New Jersey
Members of the Woman's Auxiliary are Invited.
Viking Room, 13th Floor

MONDAY, MAY 14, 1956

10:00 a.m.—Registration; Breakfast, Luncheon, and Dinner Tickets
Sun Porch, Lounge Floor

1:00 p.m.—Pre-Convention Board Meeting
Mrs. Andrew C. Ruoff, President, presiding.
Vernon Room, Lounge Floor

3:30 p.m.—Tea
All physicians' wives are cordially invited.
Rutland Room, 1st Floor

8:30 p.m.—General Session of the 190th Annual Meeting of The Medical Society of New Jersey
Members of the Woman's Auxiliary are Invited.
Viking Room, 13th Floor

TUESDAY, MAY 15, 1956

9:00 a.m.—Registration; Breakfast, Luncheon, and Dinner Tickets
Sun Porch, Lounge Floor

9:00 a.m.—General Session
Mrs. Andrew C. Ruoff, President, presiding.
Vernon Room, Lounge Floor

12:30 p.m.—Luncheon
Rutland Room, 1st Floor

2:30 p.m.—General Session (continued)
Vernon Room, Lounge Floor

7:00 p.m.—Dinner-Dance
Vernon Room, Lounge Floor

WEDNESDAY, MAY 16, 1956

9:00 a.m.—Inaugural Breakfast
Vernon Room, Lounge Floor

10:00 a.m.—Post-Convention Board Meeting
Mrs. Bertram J. L. Sauerbrunn, President, presiding.
Vernon Room, Lounge Floor

11:15 a.m.—Instruction Session for New State Officers, Chairmen, and County Presidents
Mrs. Bertram J. L. Sauerbrunn, President, presiding.
Vernon Room, Lounge Floor

12:00 noon—President's Luncheon for Incoming County Presidents
Mrs. Bertram J. L. Sauerbrunn, Hostess
Rowsley Room, 1st Floor

GENERAL SESSION

TUESDAY, MAY 15, 1956

Presiding: Mrs. Andrew C. Ruoff, President

Vernon Room, Lounge Floor

9:00 a.m.

1. Invocation
   Rev. Richard L. Robinson, First Baptist Church, Atlantic City
2. Pledge of Loyalty to the Woman's Auxiliary to the American Medical Association
   Mrs. Paul E. Rauschenbach, Immediate Past-President
3. Welcome
   Mrs. Irving C. Shavelson, President, Woman's Auxiliary to the Medical Society of Atlantic County
4. Response
   Mrs. Bertram J. L. Sauerbrunn, President-Elect
5. Memorial Service for Departed Members
   Mrs. Oswald R. Carlander, Fellowette
6. Convention Announcements
   Mrs. Harry Subin, Chairman
7. Reports

2:30 p.m.

8. Reports and Discussion
9. Report of Nominating Committee
10. Election of Officers for 1956-57

LUNCHEON

TUESDAY, MAY 15, 1956

Rutland Room, 1st Floor

12:30 p.m.

honoring

Mrs. Andrew C. Ruoff, President

Presiding
Mrs. David B. Allman

Greetings
Vincent P. Butler, M.D., President, The Medical Society of New Jersey

Guest Speaker
Mrs. Mason G. Lawson, President, Woman's Auxiliary to the American Medical Association

Presentation of President's Pin
To: Mrs. Andrew C. Ruoff, President
By: Mrs. Paul E. Rauschenbach, Immediate Past-President

INAUGURAL BREAKFAST

WEDNESDAY, MAY 16, 1956

Vernon Room, Lounge Floor

9:00 a.m.

Invocation
Rev. Frank Van Hise Carthy, Trinity Episcopal Church, Cranford

YOUR HANDSOME INVESTMENT
Edward G. Bourns, M.D., Past-President, Union County Medical Society, Westfield

SCIENTIFIC EXHIBITS

Lounge Floor

Exhibit Hours: 9:00 a.m. - 5:00 p.m., Monday and Tuesday, May 14 and 15, 1956;
9:00 a.m. - 3:00 p.m., Wednesday, May 16, 1956

Booth 1. Induction of General Anesthesia with a New Ultra-Short Acting Agent, Neraval®—Electrocardiographic Studies. Irving M. Riffin, M.D., St. Vincent's Hospital; and Max Block, M.D., Mountainside Hospital; Montclair.

Induction of general anesthesia with a new intravenous agent, Neraval®, is presented. The chemical relationship of Neraval® to other thiobarbiturates is shown, and clinical results with this agent are described.

Continuous electrocardiographic tracings, taken from the time of venipuncture to two minutes following injection of Neraval® show cardiac rate and rhythm during induction of anesthesia.

Advantages of Neraval®, including a markedly shortened recovery period after anesthesia, as well as occasional difficulties in technic are also presented.

Booth 2. Surgical Revascularization of the Heart. N. A. Antonius, M.D., L. G. Massarelli, M.D., A. D. Crecca, M.D., J. J. McGuire, M.D., and J. V. Crecca, M.D., St. Michael's Hospital, Newark.

Demonstration of the physiologic principles and laboratory experiments upon which the surgical treatment of coronary artery disease is based. Emphasis is placed on the Beck I operation as a feasible procedure in selected cases of arteriosclerotic heart disease. The criteria for the selection of such cases for surgery are enumerated. Results of clinical application of this operation with up to five years' postoperative observation are presented.

Booth 3. Problems of Plastic Surgery. Arthur W. vonDeilen, M.D., J. Curtiss Lamp, M.D., and James B. Cox, M.D., Graduate School of Medicine, University of Pennsylvania, Philadelphia, Pa.

Large colored transparencies of plastic problems in view boxes. Automatic slide changer shows other problems continuously.

Booth 4. Plastic Surgery and the Pediatrician. Michael L. Lewin, M.D., Paterson.

This exhibit presents plastic surgery cases of interest to the pediatrician. It includes congenital and acquired deformities in children. Examples of facial clefts, varied tumors, deformities of extremities and genitalia are presented and the treatment is outlined. Problems of treatment of trauma, burns, lacerations as related to children are discussed.

Purpose of the exhibit is to familiarize the pediatrician with the surgical problems in some of the cases he may see in his practice.

Booth 5. The Roentgen Diagnosis of Hyperrugosity of the Stomach. Daniel Wilner, M.D., Atlantic City; and Robert Sherman, M.D., New York, N. Y.

"Hyperrugosity" describes a non-malignant condition of the stomach characterized by voluminous mucosal folds that simulate the convolutions of the brain and that may at times produce filling defects of tumor-like character. Over 50 such cases have been observed during the past seven years. Most were discovered in asymptomatic individuals from the Strang Cancer Detection Clinic, Memorial Center. Hyperrugosity assumes particular importance because of the frequency with which it may be confused roentgenographically with carcinoma, lymphoma, polyposis and gastritis.

Booth 6. Follow-up Study of Hypertension. Royal S. Schaaf, M.D., Annie Mary Lyle, F.S.A., and Charles E. Kiessling, M.D., Prudential Insurance Company of America, Newark.

This is a mortality study of hypertension of all grades, showing that even a slight increase in blood pressure above normal levels results in an increased death rate. Some observations are made on the clinical progress of the group and on the incidence of electrocardiographic abnormalities.

Booth 7. Use of Trilene® in Obstetrical Labor. Gene L. D'Alessandro, M.D., Rolf Vlatten, M.D., George Matheke, M.D., and L. Felmly, M.D., Presbyterian Hospital, Newark.

A statistical study is presented of 173 patients in which Trilene® was used as an analgesic agent for the relief of pain in labor. Ninety-two per cent were made comfortable during labor by the inhalation of this agent. In a group of 70 used as controls, routine medication was administered without Trilene®. In this controlled series only 30 per cent of the patients were comfortable.

Trilene® is a potent analgesic agent and of great value in the relief of pain during labor. There were no significant adverse effects or complications.

Booth 8. Problems in the Clinical and Pathological Diagnosis of Vulva Lesions. Henry C. Falk, M.D., and Arthur B. Hyman, M.D., Beth Israel Hospital, New York, N. Y.; and R. V. Chapple, M.D., Ortho Research Foundation, Raritan.

Kodachromes show the clinical features of vulval problems so as to indicate difficulties in clinical diagnosis. Photomicrographs are shown in an attempt at verification of the clinical diagnosis by histologic examination. How far can one correlate the clinical features and the histologic findings in these conditions, particularly in kraurosis? Can one determine, from the clinical and histologic points of view, a definite answer to the question: what is kraurosis vulvae? Difficulties in the histologic and clinical diagnosis of various vulvoses are stressed.

Booth 9. The Treatment of Gastric Cancer. G. T. Pack, M.D., G. McNeer, M.D., R. Booher, M.D., T. R. Miller, M.D., L. Bowden, M.D., C. McPeak, M.D., and J. Fortner, M.D. (Gastric Service); H. T. Randall, M.D., K. Roberts, M.D., M. Schwartz, M.D., and A. Ley, M.D. (Experimental Physiology); D. Sunderland, M.D., and L. Ortega, M.D. (Pathology Department); Memorial Hospital, New York, N. Y.

The exhibit covers three phases in the treatment of cancer of the stomach:

1. Pathologic studies based on autopsy and investigation of specially cleared surgical specimens for lymph node distribution of metastasis. As a result, certain conclusions are drawn regarding surgical technic.
2. Metabolic changes in humans after total gastrectomy.
3. End results of treatment.

Booth 10. Reticuloendothelioses in Childhood. Harold W. Dargeon, M.D., and Lois Murphy, M.D., Pediatric Service and Children's Tumor Registry, Memorial Center for Cancer and Allied Diseases, New York, N. Y.

Proliferative reactions of the cells of the reticuloendothelial system occur in a wide variety of pathologic states—metabolic, infectious and neoplastic. The clinical evidences are often typical and recognizable without difficulty. Others may be unusual and the diagnosis may present formidable problems. Since the prognosis and diagnosis vary, differentiation is of major importance. Examples of lipid and non-lipid varieties—"idiopathic" and infectious are illustrated and the therapy, if indicated, is described.

Booth 11. The C-reactive Protein Determination in Heart Disease. Irving G. Kroop, M.D., and Nathan H. Shackman, M.D., Jewish Chronic Disease Hospital and Jewish Hospital, Brooklyn, N. Y.

C-reactive protein in the blood in a sensitive but non-specific indicator of tissue necrosis and inflammation. In the absence of other stimuli for its formation, serial determinations have proved an excellent index of rheumatic activity and thereby a guide for adequate steroid therapy. The test has also been valuable in assessing the subsidence of inflammation in myocardial infarction, post-commissurotomy syndrome and non-specific myocarditis-pericarditis. Furthermore, in coronary insufficiency with only RS-T and T wave changes in the electrocardiogram, a positive test is diagnostic of significant myocardial necrosis. The CRP determination will be compared with the sedimentation rate, plasma fibrinogen and serum glutamic-oxalacetic transaminase.

Booth 12. Effect of Anticholinergic Drugs on Normal and Abnormal Gastrointestinal Motility. Wolfgang F. Vogel, M.D., Paterson; and G. Kenneth Hawkins, M.D., Bloomfield.

Using the technic of a barium meal, x-ray examinations were made before and after administration of various anticholinergic drugs. Patients included normal individuals and those with hyperperistalsis, peptic ulcer, gastric resection, colon resection, and pylorospasm. Comparative effect on gastrointestinal motility in each of these conditions is demonstrated by a series of x-rays. Case histories are included.

Booth 13. New Approach—Surgery of Mitral Insufficiency. Robert P. Glover, M.D., Julio C. Davila, M.D., Robert G. Trout, M.D., and O. Henry Janton, M.D., Presbyterian Hospital, Philadelphia, Pa.

The concept of circumferential constriction or purse-stringing of the cardiac valves for the relief of insufficiencies has been studied experimentally in our cardiovascular research laboratory at the Philadelphia Presbyterian Hospital for the past three years. This has led to a surgical technic that is both feasible and safe. This operation does not require the introduction of foreign material across the lumen of the cardiac chambers. It also involves no more intracardiac manipulation than does a commissurotomy and results in no significant myocardial trauma. This principle, with or without concomitant commissurotomy, appears applicable to most forms of mitral insufficiency.

This exhibit depicts the pathology and physiology of the lesion, the technic of the operative approach, the three year experimental background, and its more recent clinical application.

Booth 14. Twenty-five Years' Maternal Welfare Work in New Jersey. Special Committee on Maternal and Infant Welfare of The Medical Society of New Jersey, and the Bureau of Maternal and Child Health of the New Jersey State Department of Health.

This exhibit highlights the reduction in maternal mortality in New Jersey since the organization of the Maternal Welfare Committee of The Medical Society of New Jersey working in conjunction with the Bureau of Maternal and Child Health of the New Jersey State Department of Health.

Booth 15. The Urogenital Sinus and Hermaphroditism. Nathaniel Finby, M.D., David H. Baker, M.D., Albert J. Paquin, M.D., and John A. Evans, M.D., The New York Hospital, Cornell University Medical Center, New York, N. Y.

Persistent urogenital sinuses are seen in female pseudohermaphrodites, male pseudohermaphrodites and in true hermaphrodites. The presence of a urogenital sinus or its radiographic appearance is not diagnostic of the type of hermaphroditism.

Cysto-urethrography is valuable for the demonstration of the urogenital sinuses in patients with congenital genital anomalies or the adreno-genital syndrome. Other important diagnostic aids include careful clinical study, blood electrolyte determination, and urinary 17-ketosteroid levels. The sex of the patient is never known with certainty without gonadal biopsy.

Booth 16. Corrective Surgical Planing of the Skin for Acne Scars and Skin Defects. Harry C. Goldberg, M.D., Plainfield, and Seymour L. Hanfling, M.D., East Orange.

Surgical planing of the face (as developed by Dr. Abner Kurtin) is the most outstanding development in dermatology in recent years. Many minor improvements in technic have been developed since it was first described. Our method is ex-

plained and the equipment is exhibited. Sequences of pictures show the actual procedure, the healing process, and the before and after results of a number of patients treated. Photomicrographs of the skin show the depth of the planing process. The exhibit presents evidence of the considerable improvements of the pits, scars, and pock marks of the face following *Corrective Surgical Planing of the Skin.*

Booth 17. Low Back Pain in Industry. Henry H. Kessler, M.D., and Earl F. Hoerner, M.D., Kessler Institute for Rehabilitation, West Orange.

This exhibit demonstrates the part that workmen's compensation plays in disability with low back injury. It highlights medical aspects and treatment. It demonstrates the significance of the emotional picture and shows that the patient's single complaint of pain, as an isolated factor, is meaningless. Eighty per cent of the cases reviewed showed dominant neurotic behavior and 20 per cent definite evidence of degenerative disc disease. Complicating these major classifications is the complex of social, economic, administrative and personality elements which make up the compensation system. The exhibit suggests that the present compensation system is inadequate to control neurotic behavior, relieve symptoms or reduce the period of disability. It recommends that the system be analyzed and that a change be made in methods with orientation towards the rehabilitation system.

Booth 18. Treatment of Carcinoma of the Bladder. Irving Maisel, M.D., Maxwell Malament, M.D., and Kenneth Forbes, M.D., Veterans Administration Hospital, East Orange.

Various types of carcinoma of the bladder are shown with different approaches. Each variety is demonstrated with characteristic x-ray, montage of the gross pathology, microphotograph and diagrammatic representation of type of treatment carried out from simple fulguration to cystectomy with ureteral transplant.

Booth 19. New Jersey Rehabilitation Commission.

The New Jersey Rehabilitation Commission exhibit briefly outlines, through pictures and posters, the work of the Commission in returning mentally and/or physically disabled workers to the fullest mental, vocational, social and economic usefulness of which they are capable.

Vocational rehabilitation is not charity. It is a public service for the disabled of New Jersey comparable to public education, public health and other activities for the welfare of the people.

Booth 20. Cancer of the Thyroid—How Dangerous is the Disease? Harold A. Kazman, M.D., Director; Martin R. Rush, M.D., Peter J. Guthorn, M.D., and Charles Zukaukas, M.D., Surgical and Pathological Services, Monmouth Memorial Hospital, Long Branch.

This is an effort on the part of the surgical and pathologic services of a community hospital to answer the confusing question of what to do when a diagnosis of thyroid cancer is established.

Booth 21. Aspiration Biopsy in Head and Neck Surgery. William G. Bernhard, M.D., W. Franklin Keim, M.D., Harold Grubin, M.D., Hlemuth Wanner, M.D., and Gerhard Sewekow, M.D., Hospital of St. Barnabas and for Women and Children, Newark.

Charts and transparencies illustrate the correlation between aspiration biopsy and surgical material removed at a later date. Also shown is the technic of aspiration biopsy as applied to head and neck surgery and lymph node diagnosis. Material for this exhibit comes from over 106 cases with adequate clinical and pathologic follow-up. The transparencies will show the correlation between the aspiration biopsy and the surgical specimen.

Booth 22. Symposium Theatre. Asher Yaguda, M.D., and Kenneth W. Thompson, M.D., Academy of Medicine of New Jersey, Newark.

Filmed symposia on current subjects summarizing panel discussions at stated meetings of the Academy as follows:

"Symposium on Corticotropin Therapy"
Philip S. Hench, M.D., Moderator
"Symposium on Heparin"
Irving S. Wright, M.D., Moderator
"Symposium on Vascular Head Pain"
Derek E. Denny-Brown, M.D., Moderator

Booth 23. The Bergen Community Blood Bank. Blood Bank Committee, Bergen County Medical Society.

This deals with the efforts of the Bergen County Medical Society to improve the blood procurement facilities of a rapidly-growing, highly industrialized region of New Jersey, by the creation of a centralized, incorporated, non-profit, self-sustaining, community shared and organized "Community Blood Bank," for the benefit of the citizens, the doctors, and the hospitals of Bergen County, and all others who maintain credit with the "Bergen Community Blood Bank."

Booth 24. Pneumoencephalographic and Electro-encephalographic Studies in Psychosurgery. M. P. Rosenblum, M.D., L. Barnes, M.D., and W. Ehrlich, M.D., Veterans Administration Hospital, Lyons.

Photographs are presented of air studies, electroencephalographic tracings and charts of statistical data of lobotomies at the Veterans Administration Hospital at Lyons, N. J. The study reports the incidence of convulsions, neurologic symptoms and other sequelae, as well as findings on postmortem study of the nervous system.

The exhibit shows the structural changes which may follow prefrontal lobotomy, including dilatation of the anterior horns of the lateral ventricles and porencephaly.

Booth 25. Oxytocics in the Third Stage of Labor. Herschel S. Murphy, M.D., Rahway Hospital, Rahway.

The use of oxytocics in the third stage of labor is developed in a new series of 120 cases in comparison with an original (1952) study of 135 cases. Statistics are displayed showing evaluation of

oxytocics, emphasizing blood loss, pressor effect, duration of the third stage of labor and involution of the uterus. Posters illustrate the pharmacology of present-day oxytocics.

Booth 26. Tomography in the Management of Pulmonary Tuberculosis. Irving J. Selikoff, M.D., David Roth, M.D., and Robert H. Joelson, M.D., The Paterson Clinic and Barnert Memorial Hospital, Paterson.

This is a demonstration of the unique nature of tomography in managing cases of pulmonary tuberculosis. It is often essential in the evaluation of the type and extent of disease present. The information may be critical in determining the type of therapy. Serial tomography aids in evaluating the therapeutic program. It may point to the need for a change of therapy or additional therapy. In many instances, tomography will reveal cavitation or other significant disease where conventional technics fail. A series of 100 cases of tuberculosis at the Paterson Clinic is analyzed as to the role played by tomography. Numerous roentgenograms demonstrating these points are shown accompanied by an explanatory commentary.

Booth 27. Technique of Chest Fluoroscopy. Paul K. Bornstein, M.D., and Irving J. Selikoff, M.D., New Jersey Chapter, American College of Chest Physicians.

This teaching film shows the advantages and disadvantages of chest fluoroscopy as a versatile and useful office diagnostic procedure. Prepared in color with the aid of an advanced image intensifier (enabling portions of the lung to be shown in greatly enlarged views) the film runs 14 minutes but will be shown at the Annual Meeting in continuous projection. It emphasizes safety factors essential for both the physician and the patient, adequate dark adaptation for best visualization and the various positions available.

Booth 28. Therapeutic and Diagnostic Use of Adrenal Cortical Steroids in Gynecology. Herbert S. Kupperman, M.D., Jeane Epstein, M.D., Meyer H. G. Blatt, M.D., and Lee Vosburgh, M.D., Departments of Therapeutics and Obstetrics and Gynecology, New York University-Bellevue Medical Center, New York, N. Y.

Adrenal cortical steroids in gynecology are important in the hirsute female and those with anovulatory defects. The exhibit shows application of the newer corticoids with comparative doses in the adrenal genital syndrome. The inter-relationship in this syndrome between the pituitary, adrenal cortex and ovaries is reviewed. The exhibit shows correction of the abnormality in the pituitary-adrenal-axis in the adrenal genital syndrome. Correction of ovulatory defects by corticoids is pointed out, as is the differential diagnosis (by corticoids) between adrenal hyperplasia and adrenal and ovarian neoplasia. The diagnosis of the obesity-hypoglycemia syndrome observed in women and its therapeutic control with hydrocortisone are illustrated. The advantages of prednisone will be emphasized.

Booth 29. Unusual Causes of Gastrointestinal Hemorrhage. J. F. Pessel, M.D., E. B. Beairsto, M.D., J. S. Wise, M.D., M. H. Edwards, M.D., G. Scaravelli, M.D., and T. K. Rathmell, M.D., The Mercer Hospital, Trenton.

Unusual causes of gastrointestinal hemorrhage encountered over an 8-year period are illustrated with Kodachrome transparencies of the gross and pertinent histologic findings. The exhibit includes examples of: Lindau-Osler-Weber disease; leiomyoma or neurinoma of the duodenum; choriostoma of the gall bladder; phlebectasia of the jejunum; congenital aneurysm of the jejunum; Meckel's diverticulum; aneurysm of the abdominal aorta and lymphosarcoma of the colon.

Booth 30. Perception of Auditory Stimuli. Herbert E. Rickenberg, M.A., Hearing and Speech Center, Newark Eye & Ear Infirmary, under the auspices of the Committee on Hearing and Speech of The Medical Society of New Jersey.

This features view boxes of transmission and reception of sound from the source (stimuli) to the perception of the stimuli by the brain. Also shown are moving pictures of children with auditory perceptive disorders to inhibit the interpretive perception of the stimuli.

Booth 31. Cardiac Surgery—Recent Modifications of Surgical Approach. Charles P. Bailey, M.D., Houck E. Bolton, M.D., Henry T. Nichols, M.D., and Harry Goldberg, M.D., Bailey Thoracic Clinic and Hahnemann Hospital and Medical College, Philadelphia, Pa.

The surgical correction of acquired lesions of the valves of the heart has undergone numerous modifications. With a continually broadening experience many improvements have been implemented. Mitral commissurotomy must deal with subvalvular stenosis as well as with the valve itself. Aortic stenosis was originally treated transventricularly, however, we are now approaching the valve through the aorta in certain cases. Many cases of multivalvular disease are now being treated surgically. The surgical technic is demonstrated in this exhibit. The results of our technics are shown. The exhibit involves an evaluation of 1500 cases operated upon.

Booth 32. Treatment of Cardiovascular Emergencies. Arthur Bernstein, M.D., Franklin Simon, M.D., J. J. Silverman, M.D., and Harold Traehtenberg, M.D., Newark Beth Israel Hospital, Newark.

This exhibit succinctly gives the diagnostic criteria and the therapy of many of the acute cardiovascular emergencies.

Booth 33. Home Accident Prevention. Samuel C. Southard, M.D., and Walter B. Stewart, M.D., New Jersey Chapter, American Academy of Pediatrics; and Renee Zindwer, M.D., New Jersey State Department of Health.

Here are three dimensional illustrations of four of the commonest home accident situations. This is designed to attract attention of viewers to the theory of home accident prevention and the extent of the problem.

Booth 34. The Problem of the Non-Adherent Surgical Dressing. James F. Connell, Jr., M.D., William Philip, M.D., Frank Gilbertson, M.D., and Louis M. Rousselot, M.D., St. Vincent's Hospital and New York University, New York, N. Y.

The aim of this exhibit is to show the evaluation of surgical dressing materials and to compare the dressings now available with the dressing meeting strict criteria selected from 128 new materials.

Special Exhibits

Booth A. Influence of Smoking on Death Rates. The American Cancer Society, New Jersey Division, Inc., under the auspices of the Special Committee on Cancer Control of The Medical Society of New Jersey.

Charts show the relative death rate (from all causes) of cigaret and non-cigaret smokers; lung cancer death rates for all types of smokers, and death rates from cancer of all sites.

Booth B. Society for the Relief of the Widows and Orphans of Medical Men of New Jersey.

Headquarters of the Widows and Orphans Relief Society during the convention where members may meet, questions may be answered and information given.

TECHNICAL EXHIBITS

Lounge Floor

Exhibit Hours: 9:00 a.m. - 5:00 p.m., Monday and Tuesday, May 14 and 15, 1956
9:00 a.m. - 3:00 p.m., Wednesday, May 16, 1956

Booth 1. Baby Development Clinic, Chicago. We offer demonstration materials: products and literature helpful in instructing prospective parents in the physical and emotional aspects of parent-child relationships arising out of the daily care of their infants and children; also aids to assist in providing emotional security for their children through school ages.

Booth 2. E. and W. Blanksteen, Jersey City. During the past year, the National Casualty Company put into effect the long term coverage Extended Professional Disability Policy with more than 75 per cent of policyholder members under the age of 60. The new policy extends total disability benefits for both accident and sickness disabilities after the coverage in the basic policy has been exhausted. Total accident disability benefits under the new policy are continued for life, and total sickness disability benefits are continued for five additional years.

The number of participating policyholders has reached an all time high.

Booth 3. Faulhaber & Heard, Inc., Newark. Information can be obtained on professional liability protection upon inquiry at the booth maintained by your official broker.

Protection is also available for professional assistants such as registered or graduate nurses, and x-ray or laboratory technicians.

Booth 4. The Liebel-Flarsheim Company, Cincinati. We cordially invite you to visit the booth in which our latest electromedical and electro surgical equipment will be exhibited. We ask particularly that you stop and see the L-F BasalMeteR, the first automatic, self-calculating metabolism unit ever offered. Capable representatives will be on hand at all times.

Booth 5. The Doho Chemical Corporation, New York. Auralgan®—the ear medication for the relief of pain in otitis media and removal of cerumen;

New Otosmosan®—the effective, non-toxic ear medication which is fungicidal and bactericidal (gram negative-gram positive) in the suppurative and aural dermatomycotic ears;

Rhinalgan®—the nasal decongestant which is free from systemic or circulatory effect and equally safe to use on infants as well as the aged;

Rectalgan®—the liquid topical anesthesia, also for relief of pain and discomfiture in hemorrhoids, pruritus and perineal suturing;

Dermoplast®—in an aerosol freon propellent spray for fast relief of surface pain, itching, burns and abrasions. Also obstetrical and gynecologic use.

Booth 6. Warner-Chilcott Laboratories, New York. A visit to our booth will pay dividends, especially in the interests of your cardiovascular pa-

tients. The company is featuring two "clinically tested and proved agents": one to help you prevent attacks of angina pectoris; the other, the most potent drug currently available for reduction of blood pressure in hypertensive patients.

Booth 7. Cameron Surgical Specialty Company, Chicago. All doctors like to see new things that will make their practice easier and more efficient. We manufacture a complete line of surgical diagnostic specialties and electro-surgical devices.

We invite you to stop at our booth to see the many improvements, including the new 1956 model Lempert Headlite that is the safest, lightest, brightest Headlite available and our new deluxe electro-surgical unit.

Our diagnostic and operating instruments are used and recommended by the leaders of the medical profession throughout the world.

Booth 8. Medco Products Co., Tulsa, Okla. The very popular Medcolator now presents its seventh model, the new Medco-Sonlator which combines all of the features of our Model "K" Medcolator plus ultrasonic energy. Here we have both electrical muscle stimulation and, from the ultrasound, mechanical stimulation producing structural heating—all in one compact unit. A patented feature is that our transducer (head) may be used as a three-way applicator to produce (1) ultrasonic energy (2) electrical stimulation, or (3) both electrical stimulation and ultra-sound through the single applicator (transducer). Plenty of your interest will be generated if you will stop to see this new unit.

Booth 9. Cosmevo Surgical Supply Company, Paterson. An impressive collection of surgical and orthopedic appliances, first aid equipment and supplies, sick room needs, and rental items will be displayed.

This year, more than ever before, the viewer will notice a more comprehensive selection and many improved design details in our displays. Visitors are urged to feel free to ask questions about any appliance or piece of equipment on the floor. Specially trained representatives will be happy to explain the functions of any item.

We are prepared to cooperate with any doctor on the design, development and manufacture of new instruments or appliances.

Booth 10. G. D. Searle & Co., Chicago. You are cordially invited to visit our booth where representatives will be happy to answer any questions regarding Searle products of research.

Featured will be Mictine®, the new safe, nonmercurial oral diuretic; Vallestril®, the new synthetic estrogen with extremely low incidence of side reactions; Banthine® and Pro-Banthine®, the new standards in anti-cholinergic therapy; and Dramamine®, for the prevention and treatment of motion sickness and other nauseas.

Booth 11. Ortho Pharmaceutical Corporation, Raritan. We cordially invite you to our booth where the well known line of obstetrical and gynecologic pharmaceuticals will be on display. Particular emphasis will be placed on Ortho preparations for conception control. Our representatives will be on hand to offer pertinent information on our products.

Booth 12. Medical-Surgical Plan of New Jersey, Newark. Medical-Surgical Plan of New Jersey —"Blue Shield"—was organized at the direction of The Medical Society of New Jersey in 1942, and is approved by the Society and its 21 component county societies. Our exhibit is an integral part of the Plan's professional service program, the purpose of which is to keep all of its more than 5,000 Participating Physicians fully informed of the Contract provisions, payment policies and administrative procedures of the Plan. Your visit will be appreciated and your questions will be answered to the best of our ability.

Booth 13. Lederle Laboratories Division, Pearl River, N. Y. You are cordially invited to visit our booth where medical representatives will be in attendance to provide the latest information and literature available on our line.

Featured will be Achromycin®, Incremin®, Diamox®, vitamins, Pathilon®, Varidase® and many other of our dependable quality products.

Booth 14. Picker X-Ray Corporation, White Plains, N. Y. "Dial-the-part" automation distinguishes the new Picker Anatomic Century II x-ray unit. Simple to use, it eliminates the need for technic charts or manual setting of separate technic factors. The operator merely "dials" the body part, makes a simple thickness-of-part setting, and pushes a button for the exposure. Coupled with this control is a new full size motor-driven table with a single x-ray tube quickly changed over from fluoroscopy to radiography.

Booth 15. Schering Corporation, Bloomfield. A cordial invitation is extended to the members of the Medical Society to visit our booth. The entire exhibit will be devoted to Meticorten® and Meticortelone®, the new corticosteroids for the treatment of rheumatoid arthritis, intractable asthma and other so-called collagen diseases. Extensive clinical and laboratory data demonstrating certain advantages of these new steroids over cortisone and hydrocortisone are shown.

Booth 16. Mead Johnson & Company, Evansville, Ind. The new Deca vitamin family for the vital first decade of life will be exhibited in our booth. Included in the new Deca family of vitamin specialties are: Deca-Vi-Sol®, for dropper dosage, a fruit flavored solution for infants and toddlers; Deca-Mulcin®, for teaspoon dosage, a pleasantly-flavored liquid for preschool children of 2 to 6 years; and Deca-Vi-Caps®, small, easily-swallowed capsules, for school-agers of 6 to 10 years. All three Deca vitamin specialties supply 10 nutritionally significant vitamins including A, C, and D, plus 7 important B vitamins.

Booth 17. U. S. Vitamin Corporation, New York. Exhibit features Panthoderm® Cream, the new and strikingly effective anti-pruritic, healing ointment. Dermatoses, long-resistant skin lesions, topical ulcers and slow healing wounds show rapid clinical improvement; pain, itching and irritation abate rapidly.

Professional samples and literature will be distributed at our booth on our complete line of nutritional specialties.

Booth 18. Miles Reproducer Company, Inc. New York. Case histories, house calls, hospital rounds, lectures, conferences, group therapy, interviews, and dictation may now be recorded at a 60-foot radius with Walkie-Recordall, Briefcase-Conference-Recorder, a lightweight self-powered battery-recorder-transcriber. It operates in or out of the closed briefcase; in car, train, plane—while mobile or stationary. Records clearly in noisy places as interferences do not block recording. No installation or acoustical room conditions required. The Voice-Activated "Self-Start-Stop" feature automatically starts and stops the recording from microphone or telephone, thus eliminating supervision and the recording of silent periods. While facilities for transcribing are available, transcription may be eliminated due to ease of handling identifiable, compact, indexed recordings without rewinding. Up to 8 hours of permanent recordings may be accumulated at intervals on an endless belt costing 25 cents.

Booth 19. A. H. Robins Company, Inc., Richmond, Va. Our exhibit features the Donnatal® "family" of antispasmodics, including the original tablets, capsules, the versatile elixir and the new Donnatal Extentabs®, which provide all-day or all-night effects on single dosage; while the formula combined with B complex and indicated in the medical management of chronic fatigue states is available as Donnatal Plus®. Also shown are Entozyme®, Pabalate®, Pabalate-Sodium Free® and the new Pabalate-HC® (Pabalate with Hydrocortisone).

Booth 20. Eli Lilly and Company, Indianapolis. You are cordially invited to visit our exhibit. The display will contain information on recent therapeutic developments. Lilly sales people will be in attendance. They welcome your questions about Lilly products.

Booth 21. Ross Laboratories (formerly M & R Laboratories), Columbus, Ohio. Current concepts in infant feeding stress the critical aspects of preventive care. Visit our booth at your convenience; your Similac® representative will be happy to discuss the physiologic role of Similac® powder and Similac® liquid in providing good growth, sound development and optimum clinical benefits. Reprints of current pediatric investigations and the latest Ross Pediatric Research Conference reports are available.

Booth 22. Ciba Pharmaceutical Products, Inc., Summit. We are featuring Ritalin®, a new mild stimulant-antidepressant. Ritalin® raises depressed patients to normal levels of psychomotor activity without amphetamine-like overstimulation or depressive rebound. Representatives will be present to answer queries on this very effective agent.

Booth 23. E. Fougera and Co., Inc., New York. We cordially invite physicians to discuss with professional service representatives new preparations of importance to their everyday practice. Descriptive literature and samples of all products will be available.

Booth 24. Geigy Pharmaceuticals, New York. Medomin®, a new kind of barbiturate, will highlight our exhibit. Indicated for safe, gentle hypnosis and reliable, sustained sedation, Medomin®, is unique in that a 7-member ring is attached to the barbiturate radical. Also featured will be Butazolidin®, nonhormonal anti-arthritic; Eurax®, antipruritic and scabicide; and Sterosan®, bacteriostat and fungistat.

Booth 25. The C. V. Mosby Company, St. Louis. We will exhibit our complete line of medical publications. Included among these titles will be the following newly released titles: Speed-Knight *Campbell's Operative Orthopedics*, Gradwohl *Clinical Laboratory Methods and Diagnosis*, Crossen *Synopsis of Gynecology*, Myers *The Interpretation of the Unipolar Electrocardiogram*, Wilder *Atlas of General Surgery*, Richards *Surgery for General Practice*, Cordonnier *Urology in General Practice*, Sodi-Pallares *New Bases of Electrocardiography*.

Booth 26. Encyclopaedia Britannica, Inc., Philadelphia. The Encyclopaedia Britannica exhibit will be a pre-publication showing of the new, revised 1956 edition of the *Encyclopaedia Britannica*, plus the valuable accessories that are part of the pre-publication offer.

Booth 27. Winthrop Laboratories, Inc, New York. Alevaire®: Nontoxic inhalant which thins sticky pulmonary secretions in bronchitis, bronchiectasis, and neo-natal asphyxia.

Lotusate®: 2 grains purple caplets, highly effective, well tolerated hypnotic providing 6 to 8 hours refreshing sleep at night. Also, available in sedative doses, ½ grain yellow and ¾ grain salmon colored caplets.

Booth 28. Ames Company, Inc., Elkhart, Ind. Clinistix® Reagent Strips. Specific for Urine Glucose. Clinistix® is a new enzyme-impregnated test paper for determining glycosuria. Based on a completely new principle in sugar testing, an enzyme system, its outstanding characteristics are:

1. Utmost simplicity and convenience in use.
2. Complete specificity.
3. Extreme sensitivity (0.01 to 0.1 per cent).
4. Qualitative accuracy.

Clinitest®, for urine sugar analysis, is standardized. This assures accurate quantitative estimations whenever and wherever a test is performed—office, ward, clinic, or patient's home.

Booth 29. Smith, Kline and French Laboratories, Philadelphia. S.K.F. is glad to introduce its new product, Thora-Dex®, at this meeting. A combination of the tranquilizer Thorazine® and the analeptic Dexadine® Sulfate, Thora-Dex® is most useful in the control of symptoms of anxiety and depression which so often occur simultaneously in neuroses and psychoses. Come to the S.K.F. booth—we'll gladly tell you more about Thora-Dex®.

Booth 30. W. B. Saunders Company, Philadelphia. Among the most recent publications of the year of special interest to the clinician are: *Current Therapy* 1956; Sodeman, *Pathologic Physiology*, 2nd edition; Laughlin, *The Neuroses;* Bland, *Fluid Balance;* Davis-Christopher, *Textbook of Surgery;* Wolff, *E.K.G.*, 2nd edition; and Modell, *The Relief of Symptoms.* Please stop in for a look at them.

Booth 31. Johnson & Johnson, New Brunswick. You are cordially welcomed to our exhibit. On display are the latest developments in surgical dressings and allied products. Kling Conform Bandage, Johnson's Elastic Hosiery, Red Cross Sterile Absorbent and new additions to the Band-Aid Adhesive Bandage family lead the list. Representatives will be glad to discuss these new products with you or demonstrate any products in the J & J line.

Booth 32. Hoffmann-La Roche, Inc., Nutley. Azo-Gantrisin® for antibacterial action and local analgesia in urinary tract infections, available in tablet form containing 500 mg. of Gantrisin® and 50 mg. of phenylazo-diamino-pyridine hydrochloride; and new Noludar®, a new, *non-barbiturate* hypnotic which provides effective relief of insomnia and tension states. Noludar® is so well tolerated that side effects such as nausea, vomiting, and dizziness, are rarely, if ever experienced with therapeutic doses. Noludar® is available in scored tablets of two strengths, 50 and 200 milligrams, and in a cordial-flavored elixir, 50 milligrams per teaspoonful.

Booth 33. S. J. Tutag & Co., Detroit. Our exhibit will feature Asminorel. This tablet provides both instant and prolonged relief in asthmatic conditions in a single dosage form. The outer layer, dissolved sublingually, contains DI-n-isopropyl Arternol®.

After 90 seconds, this initial relief is relayed and sustained by the nucleus which is then swallowed. This portion of the tablet contains a group of four proved therapeutic agents.

Booth 34. Holland-Rantos Company, Inc., New York. Physicians interested in medical contraception are invited to discuss with our representatives latest information on laboratory and clinical data concerning efficacy of Koromex products.

Also featured will be the trichomonacidal, fungicidal, bactericidal Nylmerate® Jelly and Solution for vaginal treatment and the new Hollandex Silicone Skin Ointment with natural vitamins A and D.

Booth 35. Sharp & Dohme, Inc., Philadelphia. Our exhibit presents Co-Deltra® and Co-Hydeltra®, specifically designed to provide all the benefits of prednisone and prednisolone plus positive antacid action to minimize gastric distress. Related adrenal cortical steroid preparations in endocrine disorders, collagen diseases, respiratory allergies, eye diseases and skin conditions are also highlighted. Expertly trained personnel will be pleased to discuss new dosage forms, new indications, and the latest summaries of advanced clinical reports in this field.

Booth 36 The Coca-Cola Company, Atlanta, Ga. Ice-cold Coca-Cola served through the courtesy and cooperation of the Coca-Cola Bottling Company, Atlantic City and The Coca-Cola Company.

Booth 37. The S. E. Massengill Company, Bristol, Tenn. We will exhibit: Salcort®, a judicious combination of salicylates and cortisone for the treatment of arthritic and rheumatoid affections; and Homagenets®, the homogenized vitamins. A liquid suspension in a solid form, Homagenets® may be chewed, swallowed or allowed to dissolve on the tongue. Homogenized vitamins are better absorbed, better utilized and large vitamin excesses are unnecessary.

Booth 38. Desitin Chemical Co., Providence, R. I. Desitin® Ointment—the pioneer in externl cod liver oil therapy. Indications: diaper rash, slow healing wounds, burns of all degrees, lacerations, hemorrhoids and fissures.

Desitin® Powder—a unique, dainty medicinal powder saturated with cod liver oil.

Desitin® hemorrhoidal suppositories with cod liver oil—coat ano-rectal area with soothing, lubricating cod liver oil, give prompt relief of pain, allay itching.

Desitin® lotion—the original cod liver oil lotion, soothing, protective, mildly astringent and healing, in non-specific dermatitis, pruritis, poison ivy, et cetera.

Booth 39. Sandoz Pharmaceuticals, Hanover. We cordially invite you to visit our display of: Cafergot®—available in oral and rectal form for effective control of head pain in migraine and other vascular headaches; Bellergal®—valuable as an autonomic inhibitor in a variety of functional ills —the volume of favorable clinical reports is constantly increasing; and Fiorinal®—a new approach to therapy of tension headaches and other head pain due to sinusitis and myalgia. Our representatives in attendance, will glady answer questions about these and other Sandoz products.

Booth 40. Walker-Gordon Laboratory Company, Plainsboro. You are invited to taste-test Walker-Gordon Certified milks at our booth. You will find there the new Certified Lo-Sodium Milk, which has been especially processed to reduce its sodium content from around 500 to less than 50 milligrams per quart. Walker-Gordon Acidophilus milk, Certified pasteurized milk and Certified skimmed milk will also be available.

Our Certified milk farm in Plainsboro is the world's largest farm producing Certified milk. It

includes over 2400 acres of farm land and 2690 cows and growing heifers.

It is the home of the famous Rotolactor, the purpose of which is to make possible the production of the highest quality milk.

Our Certified milk is distributed in the metropolitan areas of New York and Philadelphia and in the State of New Jersey by many leading milk dealers.

Booth 41. Lynn Pharmacal Co., Camden. A cordial invitation is extended to you to visit our booth where three delayed action, timed disintegrating capsules will be featured. Deledex®: a 15 milligram Dextro-amphetamine; Lynnspast® G. R.: A sedative-antispasmodic; and of course, the famous Rabudex® formula in an attractive gradual release capsule called Rabudex®—G. R.

Our representatives will be gald to answer any inquiries on our products.

Booth 42. Center Laboratories, Port Washington, N. Y. We provide the physician with a complete allergy service for the diagnostic investigation and treatment of the patient with allergenic symptoms. Diagnostic allergenic extracts both for scratch and intradermal testing, individually or as complete sets supplied in specially designed containers, will be exhibited. Treatment sets and individual vials of therapeutic allergens will be featured along with accessory office equipment. Descriptive literature and instructions for the use of allergenic extracts for testing and treatment along with suggested dosage schedules are available. Our staff welcomes your visit and will be available to answer your questions.

Booth 43. R. J. Reynolds Tobacco Company, Winston-Salem, N. C. Welcome to our exhibit! You are cordially invited to receive a cigaret case (monogrammed with your initials) containing your choice of Camel, Cavalier King Size, or Winston, the distinctive new king size filter cigarette.

Booth 44. Maltbie Laboratories Division, Wallace & Tiernan, Inc., Belleville. You are cordially invited to visit our exhibit to meet our representatives and discuss our ethical pharmaceutical products. Featured items will be Desenex® and Sulfundek®, The well-known fungicides; Cholan HMB®, for comprehensive biliary therapy; Malcotran®, the potent anticholinergic with wide margin of safety; and Calpurate®, for improved cardiac function and increased diuresis.

Booth 45. E. R. Squibb & Sons, New York. We have long been a leader in development of new therapeutic agents for prevention and treatment of disease. The results of our diligent research are available to the medical profession on new products or improvements on products already marketed.

We are pleased to present up-to-date information on these advances for your consideration.

Booth 46. Organon, Inc., Orange. Physicians are invited to visit our booth where will be exhibited Cortrophin-Zinc®. Cortrophin-Zinc® is an Organon exclusive representing the latest advance in ACTH therapy: a truly long-acting aqueous suspension which provides the complete physiologic action of ACTH, enhanced, prolonged, and with convenience of administration never before possible. It is available in 5 c.c. vials, each cubic centimeter of which provides 40 U.S.P. units of purified corticotropin with 2.0 mg. of zinc for repository action. Because of modification of ACTH by zinc, each c.c. of Cortrophin-Zinc® provides therapeutic ACTH activity for periods of from 24 to 72 hours. Cortrophin-Zinc® need not be heated prior to administration; it is a fine aqueous suspension which flows freely through a 26 gauge hypodermic needle. Consequently, it is easy to inject. Because of its enhanced and prolonged ACTH activity, Cortrophin-Zinc® may be given effectively in lower doses and in fewer injections than any other type of ACTH.

Booth 47. Jackson-Mitchell Pharmaceuticals, Inc., Culver City, Calif. We are exhibiting Meyenberg evaporated powdered goat milk, the natural substitute milk in cow milk allergies, and Hi-Pro, a high protein, low fat, powdered cow's milk. Chilled refreshing goat milk is being served so you can taste its pleasant flavor.

New literature on all products is available.

Booth 48. Bristol-Myers Products Division, New York. Please stop by for information on new product developments and for a personal supply of Bufferin®—the faster acting, better tolerated salicylate; Ammens® Medicated Powder—an unusually fine blend of zinc oxide, boric acid, and hydroxyquinolin; and other Bristol-Myers products.

Booth 49. American Ferment Co., Inc., New York. The demonstration of Caroid® will explain why Caroid and Bile Salts Tablets® and Alcaroid Tablets® provide unusual advantages when laxation or antacid therapy is indicated. Other products featured will be the palatable Essence of Caroid® for improving digestion and utilization of dietary proteins; and Supligol®, the whole bile-ketocholanic acid compound for management of early biliary dysfunction.

Booth 50. South Jersey Surgical Supply Co., Red Bank. We will demonstrate the latest technics in ultrasonic therapy. Also on display will be a high power office x-ray at an extremely low price. All company personnel in attendance have attended the American Institute of Ultrasonics in Detroit.

Booth 51. The Baker Laboratories, Inc., Cleveland. You are invited to visit our booth where Baker's Modified Milk and Varamel, two successful products for infant feeding, are on display.

Our representatives will be glad to discuss the practical application of Grade A milk, adjusted fat composition, zero curd tension, synthetic vitamins and other important factors which help to eliminate many of the problems in modern infant feeding.

Booth 52. Baby Service, Inc., Newark. New Jersey's leading diaper service will be on hand once again to greet our friends of the medical profession. As in past years we will have our Baby Service Rose for each lady.

The exhibit will feature diaper service for home and hospital, with full explanation of the scientific reasons for the safety and superiority of Baby Service.

Attending members of the Society, their families and friends are cordially invited to stop at our booth.

Booth 53. C. B. Fleet Company, Inc., Lynchburg, Va. During the past fifty years Phospho-Soda® (Fleet) has been a symbol of elegance in sodium phosphate medication. Fleet Enema Disposable Unit—an enema solution of Phospho-Soda® (Fleet)—is a worthy companion product. The single use unit simplifies and assures satisfying preparation for proctoscopy and as a routine enema it is a boon to the hospitalized patient.

Booth 54. Ayerst Laboratories, New York. Products to be on display are Premarin®, Premarin Intravenous® and Cytoferin®. Physicians are cordially invited to stop by this booth to discuss these or any Ayerst specialties in which they may be interested.

Booth 55. The Borden Company, New York. There's no better place to talk over the latest information on infant feeding than our booth. On display is the complete line of Borden infant formula products for every feeding purpose or preference. If you're encountering hyperirritability or excoriation, you'll be interested in Bremil®, a formula patterned upon breast milk. If you suspect milk allergy in some of your patients, you'll find the answer in either liquid or powdered Mull-Soy®, leading hypoallergenic food. For prematures, or for digestive disturbances demanding low fat and high protein, Dryco® provides an ideal, flexible formula base. And if your preference is for liquid products, you'll want the latest facts about Biolac®.

Booth 56. Gerber Products Company, Fremont, Mich. When milk is contraindicated as the basic food for infants, Gerber Meat Base Formula can provide a nutritionally adequate replacement. It is well accepted and tolerated by infants of all ages. Your Gerber detailman invites you to evaluate Meat Base Formula and the complete line of supplementary baby foods.

You are also invited to review new editions of our baby care booklets. Each is designed especially for distribution by physicians. Each provides noncontroversial information in simple, easy-to-understand language. The service is complimentary.

Booth 57. Pfizer Laboratories, Brooklyn. Our exhibit again will be in the spotlight with its new and original concept of anti-stress, anti-infective therapy—Tetracyn S. F.® and Terramycin S. F.® (Stress Fortified). Also, the complete line of our antibiotics and Steraject® as well as the new specialties, Bonamine®, Tyzine®, Toclase® and the complete line of steroid hormones including Cortril® and the latest corticosteroid Sterane® (brand of prednisolone).

Booth 58. White Laboratories, Inc., Kenilworth. Stimulate appetite—improve muscle tone—speed convalescence through a more efficient utilization of protein. "Correct proportion of amino acids to each other in the diet is more important than total intake." Our L-lysine preparations—Lactofort®, Cerofort® tablets and Cerofort® elixir—raise milk, cereal and vegetable proteins to high values.

Booth 59. Abbott Laboratories, North Chicago. A new non-barbiturate hypnotic, Placidyl®, (ethchlorvynol, Abbott) will be among the new products exhibited. Also shown will be Nembu-Serpin Filmtabs®, (Nembutal® and reserpine, Abbott), a new sedative, tranquilizer and antihypertensive; Desbutal,® new mood-improvement drug; and erythrocin Filmtabs (Erythromycin®, Abbott), an antibiotic providing specific action against coccic infections and minimal risk of side effects. We will also exhibit Iberol Filmtabs® containing intrinsic factor concentrate, B_{12}, iron and other vitamins; Optilets®, high-potency therapeutic multivitamins; Vi-Daylin®, a homogenized mixture of seven vitamins; Selsun®, for control of seborrheic dermatitis; Pentothal® sodium, the intravenous anesthetic agent, and our complete line of intravenous solutions and equipment.

Booth 60. The Purdue Frederick Company, New York. We will feature: Senokot®—the new nonirritating, highly palatable constipation corrective acting selectively on the parasympathetic (Auerbach's) plexus in the large bowel, physiologically stimulating the neuromuscular defecatory reflex to reproduce natural bowel function.

Pre-Mens®—the multidimensional premenstrual tension therapy, correcting water retention, hypoglycemia and decreased protein metabolism characterizing this syndrome.

Colpotab®—a proved highly effective Tyrothricin trichomonacide and Chlorogiene® — a hygienic douche formulation will also be presented.

Booth 61. Burroughs Wellcome & Co. (U.S.A.) Inc., Tuckahoe, N. Y. New Products—The extensive research facilities of B. W. & Co., both here and in other countries, are directed to the development of improved therapeutic agents and technics. Also much basic theoretical work in our laboratories and in cooperation with internationally known institutions is contributing to the reservoir of fundamental medical knowledge.

Through such research we have made notable advances related to leukemia, malaria, diabetes, and diseases of the autonomic nervous system; and to antibiotic, muscle-relaxant, antihistaminic, and antinauseant drugs.

An informed staff at our booth will welcome the opportunity to discuss our products and latest developments with you.

Booth 62. Bilhuber-Knoll Corporation, Orange. Oral Metrazol® is indicated for the aged patient where senile confusion, convalescence or fatigue are present. New information and literature on this therapy are available and your discussion is invited.

Information concerning the use of Tensodin® in coronary disease as well as Dilaudid®, Bromural®, Quadrinal®, Theocalcin® and other Bilhuber chemicals is also available. You are invited to discuss these preparations with our representatives.

Booth 63. Saratoga Springs Authority, Saratoga Springs, N. Y. This exhibit depicts the components of a Spa regime and stresses the value of Saratoga natural mineral water baths in arthritis and rheumatism, hypertension and coronary artery disease. It points out that a "health vacation" is good preventive medicine in this modern age of stress. Saratoga Spa literature will be made available.

Booth 64. Lissco Medical Company, Inc., Newark. For months our salesmen were chafing at the bit waiting for convention time. They are all ready to show some very exciting new machines and gadgets. Make sure you stop to see them. Our managers spend time and effort all year to gather the newest things for this convention.

Booth 65. The Upjohn Company, Kalamazoo. Members of the medical profession are invited to visit our booth where members of our professional detail staff are prepared to discuss subjects of mutual interest.

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THE MEDICAL SOCIETY OF NEW JERSEY
ANNUAL REPORTS TO THE HOUSE OF DELEGATES

President

(Reference Committee "A")

VINCENT P. BUTLER, M.D., Jersey City

The distinction of serving as President of The Medical Society of New Jersey is one which should fill any of its members with great pride. It certainly has done so to me. Being President has been an interesting, time-consuming, arduous experience, but also an immensely rewarding one. The accomplishments of the Society during 1955-56, and the loyal support which I received from all—officers, trustees, committees, woman's auxiliary, executive personnel, and members—have been adequate compensation for all the efforts expended. To all who have assisted me I wish to express a sincere debt of gratitude.

This report highlights no spectacular achievements during the year now ending, but rather it reflects the continuation of programs already set in motion by my predecessors, and, I trust, some advances in the broad areas of activity in which the Medical Society operates.

The Medical Society of New Jersey, as an integral part of organized medicine, has long since passed from a Society which can concern itself alone with the scientific and intellectual aspects of medicine. We must now face up to problems—many times not of our own making—which are vital to the profession of medicine and the health of the people of New Jersey, and which reach into the socio-economic sphere. In this ever widening scope of activity, we must have a strong, well-organized Medical Society, and we must work cooperatively with all those who share with us a genuine interest in the welfare of the people. To this end our liaison committees are working with organizations which have mutual interests with ours. Likewise, our Society has been working closely with voluntary agencies as well as with those agencies of the State of New Jersey which are concerned with medical affairs; and all this has been done under the jurisdiction of the officers and committees which have been elected or appointed by The Medical Society of New Jersey.

The past year has marked considerable progress in our mutual understanding and cooperation. To cite a few instances, as a result of our meetings with representatives of the Bar Association, the problem of medical testimony, which has long plagued both professions, has resulted in sound, concrete proposals which I trust will ultimately be beneficial to all of us. In discussion with representatives of the Hospital Association, the matter of corporate practice, as well as the problems of medical specialties—both knotty concerns—have been discussed and do not appear to be insurmountably difficult when both sides can sit and confer with a sincere desire to arrive at satisfactory solutions. A new contract of Medical-Surgical Plan, providing expansion of benefits both to the patient and the doctor, has resulted from our continued interest in voluntary pre-payment insurance.

Great strides have been made in extending the coverage of health insurance, and The Medical Society of New Jersey has long been actively interested in it, as is attested by the 12-Point Cooperative Health Program promoted by The Medical Society of New Jersey six years ago. Many of the proposals are now being carried out, and some of the others, I believe, deserve re-evaluation and implementation, as for instance:

> "5. As rapidly as possible, consistent with actuarial experience and sound administration, the services eligible under such voluntary non-profit organizations should be extended to cover all non-chronic ailments on an inclusive basis."

and

> "6. After sufficient enrollment is attained, we recommend that consideration be given the practicability of providing medical care protection on an inclusive basis to subscribers in voluntary,

non-profit plans, regardless of the financial status of the subscribers, and with no salary limitation for over-all inclusive service."

The plan followed this year—under which the four subcommittees to the Welfare Committee were enlarged and the need for many of the advisory committees thus eliminated—has worked well. I believe it should be continued. It is, however, becoming increasingly evident that the original purpose for which the Welfare Committee was originated no longer continues to be realized. I recommend the discontinuance of the Welfare Committee and suggest that the present four subcommittees assume its function and report their findings and recommendations directly to the Board of Trustees.

The method by which the Subcommittee on Legislation now functions is working well, and I recommend continuing the present set-up—utilizing the services of a legislative analyst for the subcommittee's assistance, and of keymen in each county rather than a single legislative representative working out of the Executive Offices for contact with legislators.

In public relations we are cognizant of the need for public education, but I believe we cannot hand over this important function to laymen. The thinking and training of persons not educated as doctors do not fit them adequately to understand the problems which confront us and the lofty goals which inspire us as professional men. I feel that we doctors no more need to be sold to the public by hired press agents than do our noble counterparts, the clergymen. Let each physician be conscientiously responsible individually for his own public relations, and we will need fewer hired assistants.

Our relations with the various liaison groups have been excellent, and I believe should be encouraged and continued.

We are entering upon a new era of medical education, with the establishment of a medical college in our state. Our cooperation has been sought, and I feel that it should be readily forthcoming.

It has been to me a rich and rewarding year—not because of the honors which as President I enjoyed, but because of the intimate way in which it has brought me into contact with so many of our members. The men and women of medicine have always been characterized by idealism, unselfishness, industry, and compassion. I can testify that they still are. In the past, because of these attributes in its representatives, medicine has been a profession second to none in dignity and in honor. If we remain faithful to ourselves and to our traditions, despite the threats of changing times and notions, medicine will continue as a truly noble profession, and we shall fulfill our duty and our destiny.

Secretary

(Reference Committee "A")

MARCUS H. GREIFINGER, M.D., Newark

The office of the Secretary continued to be active. Routine correspondence has been promptly answered and questionnaires from various sources completed and returned.

The Secretary attended the Annual Meeting of the American Medical Association in Atlantic City and the mid-winter meeting in Boston as well as meetings of the Board of Trustees and the several committees of which he is chairman, member, or advisor.

MEMBERSHIP

(As of December 31, 1955)

Active-Paid	5,470
Exempt	228
Total Active	5,698
Associate	243
New and reinstated members	241
Members deceased	52
Transfers in state	14
Resignation and transfers out-of-state	23
State Emeritus Members	97
State Honorary Members	4
Members dropped for non-payment of dues	61
A.M.A. Members	5,300

A.M.A. MEMBERSHIP

New Jersey membership in the A.M.A. is growing: 5,205 in 1954, 5,300 in 1955. On the basis of one delegate per 1,000 members or fraction thereof, New Jersey has six delegates to the A.M.A.

MEMBERSHIP DIRECTORY

The 1955 Membership Directory, which was our second issue, was mailed the first week of October, 1955. The directory contains a listing for each member as of June 1, 1955. We regret that a number of our members neglected to complete the questionnaire and return it by the closing date, so that their complete listings could be included. The following is a cost analysis of the 1955 Membership Directory:

Cost of publication—7,000 copies		$12,333.02
Reserve from 1953 Directory	$6,930.56	
Sales to members, hospitals, and outside agencies	2,867.50	9,798.06
Net cost of 1955 Directory		$ 2,534.96

Net cost per member—46 cents

5,569 copies distributed without charge to active members. 736 copies on hand.

Treasurer

(Reference Committee "B")

JESSE MCCALL, M.D., Newton

As the fiscal year does not close until May 31, 1956, the annual report of the Treasurer cannot be submitted at this time. An interim report will be presented to the House of Delegates on May 12, 1956 covering the accounts to that date.

Board of Trustees

C. BYRON BLAISDELL, M.D., Chairman, Asbury Park

(Reference Committee "A")

Most of the actions of the Board have been reported in THE JOURNAL, so that this report is a matter of highlighting those actions. The Board has met six times so far this year. Each meeting has been long and many of the problems weighty. I wish to record my appreciation and gratitude to all the Board members. They have served loyally and diligently in the interests of the Society. And I commend the dependable and orderly work of the numerous committees. Their generous endeavors greatly facilitated the conduct of the Society's business.

COUNCILOR, FIRST DISTRICT

At the reorganization meeting, Dr. Kenneth E. Gardner, Councilor for the First District, resigned, following his election by the House of Delegates as second vice-president. Dr. F. Clyde Bowers was elected to fill the vacancy until the 1956 Annual Meeting.

FINANCE AND BUDGET COMMITTEE

The Board re-elected Dr. William F. Costello as a Board member of the Finance and Budget Committee for a six year term.

A.M.A. PRESIDENT-ELECT

Following the 1955 Annual Meeting, letters were sent to all state and territorial medical society presidents and secretaries, informing them of New Jersey's intent to nominate Dr. David B. Allman as President-Elect of the A.M.A. in 1956. Similar letters were sent to all members of the A.M.A. House of Delegates urging their support of Dr. Allman's candidacy.

OSTEOPATHY AND MEDICINE

The Board instructed the A.M.A. delegates to use their best judgment in voting on the re-

port on this subject. We felt that osteopaths, rather than medical doctors, should take the initiative in the matter of recognition of osteopaths by medicine; and that if recognition is given to osteopaths they should be willing to eliminate the classification of osteopath.

Subsequently, the minority report of the A.M.A. Reference Committee was adopted. It was stated that osteopathy is still a cult and recommended that further action be tabled and the committee discharged with thanks; and advised that, if and when, the present "osteopath concept" is discarded by the Osteopathic Association, further conference may be held at the request of the osteopaths.

DENTAL-ORAL SURGERY

The Board instructed the A.M.A. Delegates to vote against rescinding the definition of Dental-Oral Surgery adopted by the A.M.A. House of Delegates in 1953, and to support a resolution to reaffirm the 1953 action. The A.M.A. House reaffirmed its 1953 definition: "Dental-Oral Surgery is to be limited to the diseases of the teeth and jaws and lesions of contiguous soft tissue related to diseases of the teeth and jaws but excluding malignancies."

A.M.A. REPORTS

The A.M.A. Delegates were authorized to introduce a resolution that committee reports requiring action be submitted for study to the constituent associations at least 30 days in advance of the scheduled meeting of the House of Delegates, and further providing that all reports not so submitted be deferred for consideration until the next following meeting of the House of Delegates, except by a two-thirds consent of the House. The House adopted the Reference Committee report on the New Jersey resolution, expressing sympathy with the content but referring it to the Board of Trustees for study of feasibility. The Trustees at the Boston meeting reported it believed the intent of the resolution was sound but that its implementation is impractical. Their report was adopted.

LIAISON REPRESENTATIVES AND COMMITTEES

Most of the liaison representatives and committees were continued and some others appointed. The Society now has liaison with most of the State Departments and Bureaus, the allied professions, labor and industry, the lawyers, and with organizations primarily concerned with the public health and welfare.

BLOOD BANKS

The Blood Bank Commission was authorized by the Board to act as the Society's agent in surveying the state on the relation of existing blood banks to population density; to recruit the listed blood banks into a program of integration with one another on a regional basis; to promulgate the National Institutes of Health standards of blood collection in all hospitals; to confer with the Red Cross concerning blood credit exchange; and to confer with the Director of State Medical and Health Preparedness of the Division of Civil Defense with reference to coordination of blood banks with the civil defense program.

MEDICAL TESTIMONY

A form supplied by the Bar Association for use in lieu of attendance by the physician in court in friendly judgment cases was reviewed by the Board. The following rule of the Supreme Court went into effect on September 1st:

Rule 4:56A—*Proceedings to Approve Settlements*

(C) Medical testimony as to the injuries of an infant or incompetent person given in a proceeding for the purpose of having the court approve a settlement shall be that of the attending or consulting physician unless for good cause the court shall otherwise order. Such testimony of the attending or consulting physician may be submitted by affidavit unless the court, in its discretion, shall require his personal appearance.

A special committee, in collaboration with a committee of the Bar Association, is studying the inability of lawyers to get doctors to testify in alleged malpractice cases. Any plan ultimately approved by The Medical Society of New Jersey and the New Jersey Bar Association will be submitted to the judiciary for approval.

The special committee is also studying, on a statewide basis, medical testimony in compensation courts.

1955 AMENDMENTS TO CONSTITUTION AND BY-LAWS

(Reference Committee on Constitution and By-Laws)

The proposed amendments to the Constitution and By-Laws concerning the Judicial Council and Board of Trustees, as originally presented to the 1955 House of Delegates, together with the revised amendments supplied by the Reference Committee and approved by the House, were submitted to the Society's legal counsel at the request of the Judicial Council. Counsel declared that the amendments were invalid because they had not followed the procedure set forth in Article XII and Chapter XV, which call for submission of amendments to a Committee on Revision of Constitution and By-Laws prior to introduction (a committee separate and distinct from the Reference Committee); and because the amendments voted upon at the final session of the House were substantially changed from those read at the first session.

The Board accepted the opinion of counsel, and declared the action of the House of Delegates on the amendments to the Constitution and By-Laws concerning the Judicial Council and Trustees to be invalid for the reasons given by legal counsel. The Board directed that all county societies be so notified, and that a notice of this action be published in THE JOURNAL.

A special Committee on Revision of Constitution and By-Laws was appointed, in conformity with the provision of Article XII and Chapter XV. Action was also taken by the Board to insure that in the future proposed amendments to the Constitution and By-Laws will be received in the Executive Offices by March 1 for the consideration of the Committee on Revision, and that proposed amendments in the form approved by the committee will be published in THE JOURNAL prior to the annual meeting.

These actions of the Board were based on the opinion of the Society's legal counsel and on two provisions in the By-Laws, (1) Section 5 (b) of Chapter VI, which reads: "The Board shall exercise general supervision over the affairs of the society, with authority to act for the society between annual meetings . . .," and (2) Section 16 of Chapter IX, which reads: "Special Committees may be created by the House of Delegates or by the Board of Trustees . . ."

It has been contended that a third amendment on honorary membership was accepted as validly adopted in the 1955 House of Delegates, although it had been processed only by the Reference Committee. The facts are these: The 1953 Reference Committee on Resolutions and Memorials called attention to a flaw in the regulations of the Constitution regarding election of honorary members and suggested an amendment. The matter was referred to the Special Committee on Revision of Constitution and By-Laws which drafted the amendment in proper form and submitted it to the Board of Trustees for review, after which the amendment was published in the convention issue of THE JOURNAL. The 1954 House of Delegates approved the amendment subject to final vote in 1955.

From the records of the House of Delegates and the Board of Trustees, there is evidence that all previous amendments have been reviwed by the proper committee and followed the required procedures, and none were substantially changed after introduction. Therefore, it has not been necessary heretofore for the Board to invalidate any actions of the House of Delegates affecting amendments to the Constitution and By-Laws.

HOSPITAL SERVICE PLAN

(Reference Committee "C")

The Board approved a recommendation of the Permanent Committe on Blue Shield and Blue Cross Plans that county medical society advisory committees to Medical-Surgical Plan also function on problems of Hospital Service Plan if referred to them.

Judicial Council

(Reference Committee "A")

D. F. Featherston, M.D., Chairman, Asbury Park

Apart from its work as an appellate tribunal considering matters originally dealt with by County Judicial Committees, the Judicial Council has the responsibility of supervising, directing, and keeping records of all complaints dealt with by County Judicial Committees as matters of original jurisdiction. To accomplish this, the Council, through the cooperation of County Judicial Committees, receives reports of all cases accepted for adjudication by County Judicial Committees, and of the dispositions made of them.

From the official files of the Judicial Council, we present the following resume of the operations of the Judicial Council and of County Judicial Committees for the year now ending March 31, 1956:

By the Judicial Council—

Appeal Hearings held	6
Complaints received and amicably adjusted	6
Opinions rendered	2

(a) Opinion concerning acceptability of a label proposed for affixing to boxes or bottles containing medicines prescribed by a local physician and imprinted with name, address, and telephone number of prescribing physician. The opinion disapproved the proposal.

(b) Opinion regarding the ethics and legality of New Jersey doctors' forming unincorporated associations to practice medicine, with membership limited to practicing physicians, and providing a pension plan for members giving all advantages that corporation employees have under an approved pension agreement. The opinion indicated there is nothing unethical or illegal about such incorporation.

By the County Judicial Committees:

Complaints reported as disposed of	101
Complaints still pending	25

These figures indicate a sizable increase in the number of complaints processed by County Judicial Committees. It must not be concluded, however, that the record necessarily indicates increasing dissatisfaction concerning the ethical or professional conduct of our members. The higher totals strongly reflect fuller cooperation —on the part of certain County Judicial Committees at least—in reporting upon their activities.

For this improved cooperation the Council is grateful. It urges that County Judicial Committees which have not extended such cooperation now do so, in the interest of the efficiency of the entire judicial mechanism, the satisfaction of the public by means of an instrumentality controlled by the Society, and for the protection of our members. This last consideration deserves to be stressed. It is a disservice to members if County Judicial Committees do not function promptly and dependably. Inaction or inefficiency on the part of a County Judicial Committee withholds from members complained against by the public the service and advantage of a hearing before an officially approved body of professional peers, whose judgment of the matters of the complaint are based not only upon adequate knowledge but upon a familiarity with all phases of the circumstances involved. A clear-cut decision rendered by a County Judicial Committee, which is prepared to demonstrate the impartial accuracy of its findings, liberates deserving members from the shadows of charges which otherwise might indefinitely linger, to the lasting dissatisfaction of all parties involved.

Another major concern to the Judicial Council, and therefore to The Medical Society of New Jersey, is the pressing need for revision of the by-laws dealing with the Judicial Council and County Judicial Committee, in the interest of strengthening and integrating the entire judicial mechanism. It is the hope of the Judicial Council that the House of Delegates will adopt the by-law revisions which the Council has submitted in the light of its experience with the mechanism. By doing so the House of Delegates will supply a dependable basis for progressively efficient operation of our judicial mechanism.

The Council is firmly convinced that the work entrusted to it and to County Judicial Committees is not only of immense importance in the protection of the members of our Society and of the reputation of the profession, but is a public relations service whose worth cannot be overestimated.

First District

Union, Warren, Morris and Essex Counties

F. Clyde Bowers, M.D., Councilor, Mendham

Your Councilor in the First District attended and participated in the regular meetings of the Judicial Council. There were no problems in the First District which demanded the attention of the Councilor.

Second District

Sussex, Bergen, Hudson and Passaic Counties

Joseph M. Keating, M.D., Councilor, Passaic

There were no matters that were exclusive to the Councilor for the Second District this year. He acted with the other Councilors in the meetings of the Judicial Council.

Third District

Mercer, Middlesex, Hunterdon, Somerset Counties

Charles H. Calvin, M.D., Councilor
Perth Amboy

The work of the Councilor for the Third District consisted in its entirety of matters that he dealt with as a member of the Judicial Council, which body, in its regular meetings, disposed of all items of concern to the Third District with dispatch and satisfaction.

Fourth District

Camden, Burlington, Ocean and Monmouth Counties

Daniel F. Featherston, M.D., Councilor
Asbury Park

The Councilor of the Fourth District has been impressed with the improvement in the time element involved in disposing of cases by the County Judicial Committees in this district.

There has also been a noticeable improvement in the promptness with which the report forms A and B have been submitted to the Judicial Council.

Executive Officer

(Reference Committee "A")

Richard I. Nevin, Trenton

In his report the President has enumerated the principal matters with which the Society officially concerned itself in the year now ending. To one who is intimately a part of the day-by-day operations of the Society, it is increasingly evident that the complexity and volume of matters to be dealt with are constantly on the rise. This circumstance is attributable not only to the fact that the work of Medicine itself and its range of services are continually expanding, but also to the way in which popular interest and politico-socio-economic pressures are brought to bear and work an influence upon the practice of medicine.

It has been a busy year, so busy that performance of my duties as Executive Officer has left me feeling "weary and old with service." Apart from my routine duties of publishing, editing, revising, advising, and directing—I find that within the period of eleven months I participated in ninety-three conferences or meetings; made five trips out of state on the business of the Society; and delivered eighteen speeches. All your elected officers have been similarly busy.

A significant index of official Society activity is found in the amount of mail, both incoming and outgoing, dealt with in the course of the year by the Executive Offices. Approximately 165,000 pieces of mail have been handled. This estimate does not include the mail processed by the Office of The Journal, since The Journal Office operates as an independent entity.

Through the year we have taken steps to increase the efficiency and coordination of our overall operations. Particularly it has been our aim to achieve better understanding and more effective cooperation between the State So-

ciety and component county societies. To this end on October 26, 1955, an Administrative Conference Workshop was held at the Executive Offices, for the first time. To it were invited the secretaries and the executive secretaries of all county societies. The conference was addressed by officials of The Medical Society of New Jersey, who presented outlines of the objectives and operations of official agencies of the Society in areas of common concern to both state and component county organizations. Among the topics dealt with were: general organizational procedures; the Judicial Council and county judicial committees; our legislative team; public relations, at state and local levels; patterns for administrative efficiency; and how county societies can assist. Following the formal presentation of papers a question-and-answer period was held, during which county society representatives availed themselves of the opportunity of clarifying their understanding of policies and procedures, and of pointing out phases of their local work of value and concern to The Medical Society of New Jersey. A comprehensive digest of the matters dealt with was subsequently supplied not only to all who attended the conference but to all county society offices.

This year we have also begun the compilation of a cumulative index of official actions of the House of Delegates and of the Board of Trustees. This index, we hope, will provide a long-needed means of keeping efficient track of official policies and decisions, and of insuring their effective implementation.

Mention was made earlier of the influence of popular interest and politico-socio-economic pressures upon the practice of medicine. Certainly recent happenings in New Jersey, especially in connection with what has been called "The Salk Vaccine Muddle," underscore the importance of this consideration. As one in contact not only with physicians but also with thoughtful people outside the profession, I can report that there is wide recognition of a growing tendency upon the part of members of the public and of certain groups, to invade and control the practice of medicine in the name of the welfare of the average citizen. The basic freedom of the doctor as a citizen is being ruthlessly threatened by organized efforts on the part of those who are determined to serve themselves well, no matter what the cost may be in terms of the usurpation of the rights of others. Organized aggression of this type demands organized resistance. It cannot be dealt with if doctors as individuals try to stand against it, without plan and without support.

Medicine is well organized in terms of its educational curricula and routines. The result is that Medicine is superbly successful in producing men and women who are equipped to meet and best disease and death. But to deal with political and social adversaries, Medicine needs to be similarly well equipped, and it cannot be, without unity of purpose and position and solidarity of support.

The times, therefore, confront us with a challenge. We must, by organized effort, consolidate our strength for the preservation of Medicine's ideals, rights, and prerogatives. Else we must be resigned to see them swept away. Those who are not strong enough to lead inevitably will be compelled to follow.

That is why our committees and our official agencies bulk more important with every passing day. They are the repositories of the hopes of Medicine; they are the bastions of its defenses. Freedom is at stake—the freedom of the physician, unfettered by bureaucratic or popular domination, to serve the interests of his patients according to his abilities and his conscience, and without sacrifice of the emoluments for service which are his due. This freedom, which is inseparable from the dignity of Medicine as a profession, is now under organized assault. It is for the men and women of Medicine to recognize that fact and to work together, unstintingly and ungrudgingly, to achieve effective counter organization. We have the mechanism, but we need more active membership support. As individuals we are ineffectual, but united we can be invincible.

Finance and Budget

(Reference Committee "B")

DAVID B. ALLMAN, M.D., Chairman, Atlantic City

The committee has reviewed the expenses and accounts thus far recorded for the current year. However, only after completion of the fiscal year (May 31) does it become possible to speak in precise terms of the year's finances. From our point of view, this has been a sound and satisfactory year.

JOURNAL PUBLICATION

The Finance and Budget Committee commends the Publication Committee for its excellent financial status. This committee has requested no budget appropriation for 1956-57, stating it has sufficient funds in its reserve account to cover its expenses during the next fiscal year.

AMERICAN MEDICAL EDUCATION FOUNDATION

A resolution of the 1955 House of Delegates directed that a contribution to the A.M.E.F. be considered at each Annual Meeting. In anticipation of the consideration of this by the 1956 House of Delegates, we considered the matter in connection with the preparation of the 1956-57 budget. It seems to be reliably indicated that the A.M.A. will deal directly with this on a national level in June 1956. A reference committee report adopted at the A.M.A. Boston meeting reads in part: " . . . your committee wishes to recommend that the Board of Trustees give consideration to a dues increase for its members for this (AMEF) and other purposes." It is anticipated that the A.M.A. Board of Trustees will recommend, and that the House of Delegates will approve, a dues increase to provide a portion of the increase as a contribution to AMEF and the balance as a regular dues increase.

In view of these facts, the committee felt no separate contribution should be made from New Jersey, and the committee did not include an appropriation in the proposed budget for 1956-57.

N.B. Subsequent to the meeting of the committee and the preparation of this report, it has been learned that the A.M.A. Board of Trustees is not recommending any dues increase this year. Therefore, the attention of the House of Delegates is called to its resolution of last year directing that a contribution to A.M.E.F. be considered at each annual meeting. The committee points out that if the House of Delegates authorizes a contribution to A.M.E.F. the per capita assessment must be increased to provide the funds necessary for this contribution.

1956-57 BUDGET

The following is a copy of the requested budget for 1956-57, which has the approval of your committee.

		CENTS OMITTED
A- 1	Executive Salaries	$47,890
A- 2	Executive Office Salaries	27,760
A- 3	Executive Office Expenses	2,500
A- 4	Executive Travel	2,555
A- 5	House Maintenance	24,093
A- 6	Treasurer	3,320
A- 7	Finance and Budget Committee	150
A-10	Secretary	3,175
A-11	Salary Taxes	1,520
A-12	Insurance	1,936
B- 1	Journal Publication	Nothing
B- 5	Journal Office Expenses	500
B- 6	Journal Travel	100
C- 2	Welfare Committee	800
C- 3	Legislative Committee	7,500
C- 4	Public Health Committee	1,000
C- 5	Public Relations Committee	7,500
C- 6	Medical Practice Committee	800
D- 1	President and Other Officers	4,500
D- 2	A.M.A. Delegates	9,575
D- 8	Woman's Auxiliary	7,000
D-13	Medical Education Committee	100
D-20	Medical-Dental Liaison Committee	125
D-21	Medical-Hospital Liaison Committee	125
D-22	Medical-Legal Liaison Committee	125
D-23	Directory-Membership - Physicians Placement	1,000
D-26	Medical-Pharmaceutical Liaison Committee	125
D-27	Emergency Medical Service, Civil Defense Committee	125
D-28	Medical-Nursing Liaison Committee	125
D-30	Liaison Committee with Labor and Industry	125
E- 1	Board of Trustees	2,000
E- 2	Contingent	12,000
E- 4	Judicial Council	1,000
F	Legal	1,500
		$172,649

1957 ASSESSMENT

In calculating the per capita assessment for 1957, the actual figure required to meet the budget is $37.68. The committee approves that the 1957 assessment be $30 per member, and that the balance required be taken from surplus.

RECOMMENDATIONS

1. That the proposed budget for 1956-57 in the amount of $172,649 be approved.

2. That the per capita assessment for 1957 be $30.

Medical Defense and Insurance

(Reference Committee "D")

J. WALLACE HURFF, M.D., Chairman, Newark

PROFESSIONAL LIABILITY INSURANCE

The report of the Committee on Medical Defense and Insurance for the year 1954 appeared in the March 1955 issue of this JOURNAL. In this report we summarized the historical background and the gradual evolution of medical liability insurance over the past 25 years.

We will not repeat the 1954 report. Instead we will present some of the trends toward further change in our medical liability setup which have come to the forefront during 1955. For years your committee has continually urged that members of our Society can best protect themselves by supporting our state plan of medical liability insurance. We make this statement because of the overwhelming evidence presented over a period of years. Each year shows a higher proportion of our state membership seeking coverage in our state policy, certainly a strong indication to your committee that the service rendered by the U. S. Fidelity and Guaranty Company to the individual doctor throughout the state is meeting with general approval of the profession.

Second, even though we are now insured as individual doctors, your committee has received the utmost cooperation on the part of the officials of the Company and can honestly say that the Company relationship with representatives of your State Society is more extensive today than ever before.

Third, it is self-evident that where a company covers 90 per cent of our members it can —from the standpoint of cost—carry, protect, and serve the interests of the covered physicians on a more economical basis than can competing companies, who insure a scattered few throughout the state. In the past we have surveyed medical liability coverage on a national basis. As a result of these findings we are firmly convinced that in these states now having serious problems relative to availability of medical liability coverage, there are strong indications that the volume is not in sufficient proportion to allow for a trained program that will adequately and economically serve the profession. We, therefore, conclude that the volume in New Jersey is of inestimable value to our profession, particularly should we ever arrive at a period when experience and losses show improvement. Under such conditions we would certainly be in a more favorable position from a premium standpoint.

We regret that your committee will be forced to delay its annual presentation of the loss ratio experience against premium income until a short time prior to the Annual Meeting. These reports are issued on an annual basis and date from April to April. As a result they are not available for this issue. However, we are in the process of rearranging our report so that it will extend from January to January. By so doing we will have in the future the complete data available in sufficient time to present the entire picture at our Annual Meeting.

There is a trend within our profession in which individual doctors elect to support nationally sponsored specialty groups of liability insurance. This is definitely detrimental to our interests as a whole. These plans of coverage are not new in medicine, but your committee's observations over a period of years definitely

indicate that where they have been tried they have very frequently resulted in failure. Furthermore, it is the opinion of the Medical Defense and Insurance Committee that since our State Society is the only organization that can represent our members as a whole, our loyalty should remain with this organization.

It would be impossible for the committee to function to the best advantage of our members if we allow ourselves to be side-tracked in our policy and broken up into small segments as sponsored by the national specialized groups, particularly since we in New Jersey are in a very strong position from a volume standpoint. We feel that a better approach would be for the doctors of New Jersey to utilize these groups for supplemental coverage, if so desired; but would like to point out that where doctors have coverage in more than one company it is reasonable to assume that conflicts may result between carriers as to the methods of defense and problems of settlements.

During the past year your committee has completely re-organized the statistical system in that we are not only recording our experience and loss ratios but classifying the doctors as to the type of practice undertaken, causes of malpractice, and experience data in relation thereto. This will enable us in the future to break down our losses into respective groups and will place us in a position to compare our losses with premium costs. Further, we are making photostatic copies of pertinent data as claims are being reported. These records will be broken down into the many groups of medical practices and will include dates of injuries, names of claimants, amounts of losses paid, expenses and reserves maintained, together with supporting data that we feel will be of value to the committee.

Your committee stands ready to accept or advocate a change in policy if and when such change may be found to the best interests of our doctors, but we must be guided in our recommendations by our experience.

Our first concern at all times must be to maintain and have available to the doctors of New Jersey sufficient and effective medical liability coverage.

RECOMMENDATION

Your committee is unanimous in its endorsement that we continue the services of Faulhaber & Heard, Inc., as our broker for professional liability coverage, because that firm has been for many years of inestimable value to the committee.

ACCIDENT AND HEALTH INSURANCE

During the past year, with participants totalling 3,464, we again reached an all time high in the number of policyholders under the basic Physicians' Special Policy under the group plan of accident and health insurance with the National Casualty Company.

Claims were paid by the National Casualty Company during the year to 368 members, with the smallest claim amounting to $6.66 and the highest amounting to $7,640.00.

We achieved another milestone last year in our accident and health insurance program with the National Casualty Company and our accident and health insurance representatives, E. & W. Blanksteen of Jersey City. During a ninety day enrollment period beginning November 1, 1955, approximately 78 per cent of our policyholding members under age 60 who were eligible applied for Extended Professional Disability Policy, which extended the benefits for continuous total disability for accident to lifetime, and continuous total disability benefits in the event of sickness for five additional years, for a total of seven years of coverage. And, by virtue of having passed the 75 per cent company-required participation minimum, Extended Professional Disability Policies were also issued to impaired risks.. 2,249 of our members, under the age of 60, (which was the age limit for the Extended Professional Disability Policy) out of a possible 2,884 eligibles applied for the new policy. The extended Professional Policy is renewable to the 65th birthday, but the basic Physicians' Special Policy continues to renew without age limit so long as the doctor continues in active practice and a member of the Society.

The National Casualty Company, the underwriters of this plan, is again rated by Alfred M. Best and Company as "A-plus" (Excellent), which is the highest rating that any insurance company can obtain from this insurance rating organization. Again, as of January 1, 1956, the National Casualty Company showed in their financial statement total admitted assets of $2 for every $1 of liability.

Our review of the loss ratio would definitely indicate that our program of accident and health insurance is proceeding on a satisfactory basis.

RECOMMENDATION

The committee is unanimous in its recommendation that we continue to endorse E. & W. Blanksteen as our Official Broker for accident and health coverage.

Publication

(Reference Committee "B")

J. Lawrence Evans, Jr., M.D., Chairman, Leonia

For the first time in its history, the Publication Committee comes before the House of Delegates without any request for funds. By thrifty management and by careful husbanding of accumulated reserves, we believe we can go through the next fiscal year without using any of the members' dues money. Actually, in 1955 The Journal enjoyed a net income from advertising, subscription, and sales amounting to $37,037. Since it cost $38,713 to print, bind, and distribute The Journal, there was a book loss of $1,676. It thus cost an average of 31 cents per member to put out The Journal.

Evidence continues to accumulate that The Journal is becoming better and better known. The unusual "Authors' Clinic" feature has attracted interest all over the country. Dr. Davidson's trenchant editorials have aroused considerable interest and are frequently quoted and sometimes reprinted in full by other periodicals. Beginning with the issue of August, 1955 The Journal adopted a slightly more modern dress for the cover. While we continue to retain the traditional buff cover, we have set the article titles in small bold face type so that the cover has somewhat more eye appeal.

During 1955 The Journal published 640 pages of text and 680 pages of advertising, to a total of 1320 pages. The 640 pages of text break down as follows:

326	pages of Original Scientific Articles
123	pages of State Activities
26	pages of Editorials
22	pages of Book Reviews
21	pages of Authors' Clinic
26	pages of County Society Reports
13	pages of Announcements
9	pages of Woman's Auxiliary material
14	pages of other material
640	

The Transactions of the 189th Annual Meeting were published as a 66 page supplement to the September issue.

The Journal has thus continued as an effective organ for our Society and as a compact graduate text for the doctors of New Jersey. It also serves as an instrument of communication between the officers and the members of the Society, as a record of the contributions which New Jersey has made on both the scientific and economic fronts, and as a worthy ambassador for the Society to all of the other state medical societies in the country.

Medical Education

(Reference Committee "B")

Francis M. Clarke, M.D., Chairman, New Brunswick

During the past year, because of the lack of essential personnel, the committee has undertaken no formal program. During this time there has seemed to be real promise of adequate financial and other support from sources outside the State Society. This support has not, however, definitely matured at the present date, so that the committee can only recommend a continuation of interest and effort in the hope that comprehensive, useful, and creditable programs may be instituted in the not too distant future.

Honorary Membership

(Reference Committee on Resolutions and Memorials)

Aldrich C. Crowe, M.D., Chairman, Ocean City

No names have been submitted for honorary membership in The Medical Society of New Jersey. Therefore, it has not been necessary for the committee to meet this year.

Advisory to Woman's Auxiliary

(Reference Committee on Miscellaneous Business)

Lewis C. Fritts, M.D., Chairman, Somerville

Considerable progress has been made toward the ultimate goal of complete coordination of activities of the Woman's Auxiliary with those of The Medical Society of New Jersey. The officers and committees of the Auxiliary have been most cooperative. Their programs are aimed to bring the most benefit to the Society and the medical profession. Their continued efforts in our behalf are deeply appreciated.

Annual Meeting

(Reference Committee on Miscellaneous Business)

Jerome G. Kaufman, M.D., Chairman, Newark

The Annual Meeting Committee and Section Officers met last September to discuss and tentatively formulate the scientific program for 1956. The Section on Radiology indicated that it would not meet this year.

The other 19 sections have planned excellent programs. We hope the membership takes benefit from them by attending the various meetings.

In 1954, the Section on Eye, Ear, Nose, and Throat was separated into two sections—Ophthalmology and Otolaryngology. At the conclusion of the 1955 Annual Meeting, the Section on Ophthalmology reported it was satisfied and wished to continue as a separate section. The Section on Otolaryngology stated it was the feeling of its members that the two sections should again be combined. However, after conferring, the officers of the two sections agreed that the separate sections would be retained for future conventions.

Because the convention schedule was crowded which resulted in less time available between sessions and overlapping of meetings of reference committees and scientific sections, and because the efficiency of the convention operation was being affected, it was proposed to the Board of Trustees that the opening of the annual meeting be advanced to Saturday with the first session of the House of Delegates at 2:30 p.m. This meant four specific changes this year: (1) The House of Delegates will begin a day earlier (May 12); (2) The Nominating Committee will meet a day earlier (May 12); (3) The Reference Committees will meet a day earlier (May 13), but will have longer time, and they will not conflict with scientific meetings; and (4) The seven scientific sections, scheduled for May 14, will meet on May 15. The Board endorsed the proposal.

Technical exhibits are a vital part of the annual meeting. The receipts from the rental of exhibit booths pay the full cost of the convention. Your committee urges that all who attend the convention show their appreciation and interest by visiting the technical exhibits and talking with the various representatives.

You will find much to interest you.

Members are also urged to visit the scientific exhibits. They contain information of interest and are presented in an attractive manner.

The House of Delegates last year approved the following convention dates:

1957—April 28—May 1, Haddon Hall
1958—May 18-21—Haddon Hall
1959—April 26-29—Haddon Hall

With the advancement of the annual meeting this year by one day, the dates for 1957, 1958, 1959 have been advanced accordingly and the reservations confirmed by the hotel.

Your committee suggests that the annual meeting date for 1960 be acted upon this year.

RECOMMENDATION

That the 1960 Annual Meeting of The Medical Society of New Jersey be held at Haddon Hall, Saturday, May 14 to Wednesday, May 18. (The A.M.A. will meet in Chicago in June 1960.)

Scientific Exhibit

(Reference Committee on Miscellaneous Business)

MARVIN C. BECKER, M.D., Chairman, Newark

A meeting was held on October 16, 1955 at which the applications for space were reviewed and the problem of judging awards was discussed. Thirty-five exhibits were selected. The committee regrets the necessity of refusing some desirable exhibits because of limited available space.

Exhibits will be judged by a point system. Each member of the committee will participate in the judging. Five points are to be awarded for first place, four for second place, three points for third place and two points for honorable mention. At a final meeting of members of the committee with the chairman, scores will be tabulated and prizes awarded.

Although the Committee on Scientific Exhibits can always recommend that more space be allotted to it at future conventions, it realizes that lack of space means selection of the best material to meet the requirements and perhaps will mean a higher character of material presented.

Scientific Program

(Reference Committee on Miscellaneous Business)

EDWARD E. SEIDMON, M.D., Chairman, Plainfield

The Program Committee met with Dr. Jerome G. Kaufman, Chairman of the Annual Meeting Committee, and Dr. Seidmon, Chairman of the Scientific Program Committee, on September 18, 1955, in Trenton. All specialty sections were represented, and a program for the spring meeting was organized and laid out in plan. The sections submitted their programs by December, and they were published in the Advance Program mailed to the membership in February.

Welfare

(Reference Committee "E")

ALBERT B. KUMP, M.D., Chairman, Bridgeton

The Welfare Committee met in Trenton on four occasions during the year. The attendance and interest manifested are evidences of the importance of the matters deliberated by this group. The first meeting was devoted to the programs of the various committees as well as instructions pertaining to their duties.

Each of the following meetings was highlighted by informative presentations and discussions prior to the committee reports and recommendations. These presentations were as follows:

1. H.R. 7225—Amendment of Social Security Act to provide disability benefits, and for other purposes.
2. Medical-Surgical Plan and Salk poliomyelitis immunization.
3. A mental health program for New Jersey.

A vast amount of material has been passed on to the Board of Trustees with specific recommendations. Many have received the approval of the Board. In all, it has been a productive year and appreciation is due all who participated.

SPECIAL COMMITTES OF THE WELFARE COMMITTEE

Cancer Control

(Reference Committee "E")

GEORGE P. KOECK, M.D., Chairman, Newark

The personnel of the Cancer Committee of The Medical Society of New Jersey is identical with the medical committee of the American Cancer Society, New Jersey Division, Inc.

The cancer control program in New Jersey has expanded greatly in the last ten years. In 1945 only 11 clinics were in operation. At present 46 are functioning; 38 of these have the approval of the American College of Surgeons.

A further step in improving cancer facilities throughout the United States and Canada, is the requirement of the American College of Surgeons that a cancer registry be established as of January 1, 1956 in each hospital having a cancer program. It is the requirement of the college that a properly functioning cancer registry be in operation to record every patient, private and public, inpatient and outpatient, upon whom the diagnosis of cancer is established.

Each year a report will be made of the current work of the registry to the medical staff of the hospital, including five-year end results as they become available through continuing follow-up.

The N. J. clinics are at present subsidized by the Division. These clinics are establishing registries to function in accordance with the requirements of the American College of Surgeons and to provide an additional service both to patient and physician.

With the approval of the Welfare Committee it is the plan of this committee to conduct a professional information program for physicians in the hospitals of New Jersey. Approval is also forthcoming from the Hospital Association of New Jersey.

This program will be conducted mainly through the use of films on the various methods of diagnosis and treatment of the various sites of cancer. For this, there is available a

large supply of films and kinescopes (filming of a live television show) by many of the foremost cancer specialists.

These meetings will be held wherever and whenever the hospital chooses, so that the maximum number of doctors can be reached on this informal basis. The program will bring vital information to the physicians of New Jersey, whether they have only a few minutes to spare for one film or whether they wish to devote a much longer time to the entire program. There will be no charge for this professional program.

Maternal and Infant Welfare

(Reference Committee "E")

John D. Preece, M.D., Chairman, Trenton

The committee had an active year in 1955-56. Because of the importance of obstetrical care in guarding the newborn as well as maternal lives, the name of the committee was changed from Maternal Welfare to Maternal and Infant Welfare.

The usual work of classifying and studying maternal deaths in New Jersey has continued in conjunction with the Bureau of Maternal and Child Health of the State Department of Health.

The committee is sponsoring an exhibit of "Twenty-Five Years of Maternal Welfare Work in New Jersey" at the 1956 Annual Meeting.

Subcommittees • • •

Legislation

(Reference Committee "E")

C. Byron Blaisdell, M.D., Chairman, Asbury Park

The 1955-56 reorganization meeting of the Subcommittee on Legislation was May 15, 1955, in Trenton. Its modus operandi and results were evaluated as a guide to possible improvement for 1955-56. It was decided to test again the current system of utilizing legislative keymen in each of the counties as well as in each of the fourteen congressional districts.

While this system puts heavy responsibility on the executive offices and staff, it is giving the Society an improved and centralized legislative file ready for reference and is a guide for action in line with the Society's established position on any current issue.

For speedy results and for uniform expression, the Executive Officer, after conferring with the chairman and frequently with the President, acts for the keymen in mailing reports to the legislators, always in the name of the keymen who in turn are notified to act at the county or district level.

New kits with the "Plan for Cooperative Legislative Action" were again sent to each keyman and to the new members of the committee. The results will be studied at the end of this year's activity.

The legislative analyst was reemployed for screening current legislation, of which this year there have been 463 bills introduced in the Assembly and 193 in the Senate.

The reception to the legislators was again decided to be held in Trenton on March 26, and was a very successful affair. Eighteen senators out of the 21 appeared, 50 of the 59

assemblymen appeared, and a larger number of secretaries and associates than at any previous and similar function. Governor Meyner again gave generously of his time to be with us for what was a most pleasant function. Disappointing, however, was the turnout of the doctors. Many legislators asked if doctors from their counties were present, to which in far too many instances "No" had to be the answer.

NATIONAL LEGISLATION

With Dr. David B. Allman's guidance and Drs. Hollingsworth, Wegryn, and Cunniff screening at home, we have been able to keep abreast of A.M.A. analyses and recommendations. Chief interest has centered in H.R.-7225 amending the social security act and objectionable because of its "give away" provisions. The administration's disapproval to features of this bill, as voiced by Secretary Marion Folsom, has been heartening since it parallels A.M.A.'s and our own position. Through keymen and our woman's auxiliary, letters and telegrams have been sent to Senators Smith and Case, also to Sherman Adams, Presidential Assistant. We believe these letters and telegrams have been very valuable in strengthening our influence on Washington's thinking.

At present writing little has been decided at national level by Congress. The Reed-Jenkins-Keogh legislation seems to stand in a better position this year than in recent years. The Bricker Amendment is still struggling for simple wording and seems to be of more interest to more congressmen than at previous sessions. If any accomplishment is made with respect to bills in which we are interested, this will be subject of a supplemental report.

STATE LEGISLATION

In the 1955 legislature only one bill (A-393 re hypodermic needles and syringes) was passed despite our disapproval. Thus far in 1956 no decisions have been reached by the legislature on the many bills in which we are interested. This must also be the subject of a supplemental report if action has taken place by May.

Our bill to provide for annual registration of physicians in New Jersey is ready after amendment and revision of the original draft with the assist of the Board of Trustees and the Board of Medical Examiners and will be introduced as soon as finally approved by the Trustees.

Sincere thanks and appreciation are herewith expressed for the increased assistance given by the Executive Officer, the Administrative Secretary, and the staff. Without this help little could have been accomplished.

Public Relations

(Reference Committee "E")

SAMUEL J. LLOYD, M.D., Chairman, Trenton

During the past year the Subcommittee on Public Relations carried out the duties assigned to it. During the year, the *Junior Health Hints* which have hitherto taken so much time of the committee and headquarters staff were combined into a printed form and required only one mailing rather than a series of monthly mailings. All other publications have been processed as previously.

Effort was made to interest the Society as a whole in a Public Relations Work Shop at the Annual Meeting in Atlantic City in April, 1955. This met with only indifferent success.

A continuing project, "Membership Guide Booklet" is still under study. Its format is now proposed as a folder rather than a bound volume.

Efforts to improve the public relations of the Society within the Society, with the press, and with the public were thoroughly discussed. The first of these three was implemented by the Board of Trustees by making the Assistant to the Executive Officer available to county societies for evaluating and modifying local public relations programs and procedures. Similarly, the Board of Trustees approved the establishment of an Advisory Council on Press Relations and Procedures.

Project coverage, which took considerable effort and time in previous years, was not restudied this year but will require recurring supervision in ensuing years.

Medical Practice

(Reference Committee "E")

F. Clyde Bowers, M.D., Chairman, Mendham

The Subcommittee on Medical Practice held four meetings during the year and discussed the problems referred to it. We heard the reports of our special committees, and made specific recommendations to the Welfare Committee as follows:

"Privileged Communication" should be extended to all physicians in New Jersey and legislation to this end should be proposed. This recommendation was approved.

New Jersey Rehabilitation Commission proposes that fee for physical examination be $5, urinalysis $1, serology $1 and complete blood count $3. The Welfare Committee and Board of Trustees approved these fees.

Relationship between optometry and medicine was found to be strained because of the aggressive endeavors of optometrists to usurp the field of visual eye care, and to progress toward that end by means of legislation without benefit of proper education. Your subcommittee recommended that a special committee be appointed by the President to study ways to improve this unsavory relationship.

Medical practice questionnaires were mailed last year to 5712 physicians in New Jersey to ascertain to what extent, and in what way hospitals and clinics may be indulging procedures that involve the corporate practice of medicine. Of the 2990 replies, about 20 per cent declared themselves engaged in some sort of contract practice. Members of two specialties particularly—radiology and pathology — were predominantly so involved. As a consequence, a second questionnaire (which was approved by the radiologists and the pathologists) was mailed to the members of these specialty groups. The findings thus obtained showed that the majority of radiologists and pathologists are involved with hospitals in the corporate practice of medicine, and, further, most of those so involved feel they are being exploited. Therefore, the subcommittee considered this to be in violation of the A.M.A. Code of Ethics and recommended that steps be taken to correct this situation. Meetings were held with representatives of pathologists' and radiologists' groups. We reaffirmed our position of 1947 that the practice of these specialties constitutes the practice of medicine. We were also asked to recognize these fields of practice primarily as medical services rather than hospital services so that these two specialty groups may benefit from Blue Shield payments. Although the subcommittee was in sympathy with this suggestion, no action could be taken at the present time because the majority of these two groups are involved with hospitals in the corporate practice of medicine.

To establish standard fees for workmen's compensation cases would be contrary to statute; all fees must be based upon the prevailing standards in a community which vary in different sections of the state. The subcommittee recommended (and it was approved) that conference be held by the individual county representatives with the appropriate representatives of the casualty insurance companies doing business in the State. We also considered compensation for physicians in disability insurance cases. Fees for each individual case are set by the deputy director hearing the case. The subcommittee felt it was not reasonable to assess a fee for the preparation of a form for disability insurance. It was recommended that no further action be taken on the Hudson County resolution on compensation for physicians in disability insurance cases because in the State Plan Case, the appeals examiner has seldom if ever issued a subpoena to a physician, whereas in the Private Plan Case the hearing officer awards the testifying physician a fee for his services. If, in the case under the State Plan, the claimant requests the physician to appear, the physician should make it clear to the claimant that fees for such an appearance are the direct obligation of the claimant.

Approval was given by the subcommittee to make available to the membership of the State Society the A.M.A. booklets "Guiding Principles for Industrial Nurses" and "Estimation of Loss of Visual Efficiency." It also concurred, in referring to the Publication Committee for its consideration, a suggestion that the A.M.A. Council reports be reprinted in The Journal, and that an issue of The Journal be devoted to industrial health.

Industrial Health

(Reference Committee "E")

RALPH M. L. BUCHANAN, M.D., Chairman, Phillipsburg

The special committee had no matters referred to it for consideration this year. A member of the committee attended the A.M.A. Conference on Industrial Health in Detroit, in January. On the basis of his report, the committee presented some of the conference recommendations to the Subcommittee on Medical Practice for consideration. These recommendations included making available to the membership two booklets, "Guiding Principles and Procedures for Industrial Nurses," and "Estimation of Loss of Visual Efficiency." We offer for the consideration of the Publication Committee suggestions that certain reprints and Council Reports be presented in THE JOURNAL, and that an issue of THE JOURNAL be devoted to industrial health.

While the committee has not been exceptionally active this year, it stands ready at any time its members can be of service to the Society on referred matters or on matters of advice.

Workmen's Compensation

(Reference Committee "E")

FREDERICK G. DILGER, M.D., Chairman, Hackensack

This committee considered the Bergen County Resolution on Schedule of Fees in Workmen's Compensation Cases and recommended action to be taken on a local (County Society) basis. State-wide action is contrary to statute.

The Hudson County Resolution concerning compensation for physicians in disability insurance cases was also considered and recommendations made.

There was considerable discussion relative to improving the quality of medical testimony in the Workmen's Compensation Bureau, but no definite conclusion was reached. Further study is warranted.

Public Health

(Reference Committee "E")

SAMUEL BLAUGRUND, M.D., Chairman, Trenton

The Subcommittee on Public Health has a large membership—*27*—with each county society represented as well as practically all the branches of medicine which have a direct dealing in matters of public health. During the year 1955-56, the general committee—especially and by means of its special groups in Chronic Illness, Hearing and Speech, Vision, Routine Health Examination, School Health, and Community Health Services—have striven to keep abreast of all developments of public health interest.

Your chairman was again this year privileged to serve as the liaison representative be-

tween the State Department of Health and The Medical Society of New Jersey. He also was appointed by the State Commissioner of Health, with the approval of the Board of Trustees, as a member of the New Jersey Advisory Committee on Poliomyelitis Vaccine. Dr. William F. Matthews and Dr. Carl E. Weigele, among others, were also on the committee. The purpose of the committee was to "advise the commissioner concerning the equitable allocation of New Jersey's share of poliomyelitis vaccine within the state."

Poliomyelitis Vaccine — Four points proposed through the Public Health Committee were approved by the Board of Trustees in November.

1. We reaffirm our position in support of the State Department of Health in offering to provide Salk Vaccine free of charge for the immunization of eligible medically indigent patients.
2. We believe that the distribution of the State-provided vaccine should be limited to established clinics and health stations. In this way, needy patients who are eligible for immunization can be cared for at Baby-Keep-Well Stations, appropriate clinics at the various hospitals, and private physicians' offices.
3. We oppose the establishment of special clinics.
4. Where a change of major policy is concerned and where medical services are involved, we strongly recommend the advisability of consultations between governmental agencies and The Medical Society of New Jersey prior to the release of public statements involving the general health of the community.

Copies of these points were made immediately available to county medical societies, to the Commissioner of Health, and to daily newspapers.

In February, an up-to-date summary of the current status of the Salk Vaccine situation was published in the *Newsletter,* which was sent to the membership, to cooperating agencies, and to all daily and weekly newspapers in the state.

At the March meeting of the subcommittee, representatives of the county medical societies were invited to participate in a discussion on the New Jersey vaccine program. The Deputy Commissioner of Health and the Director of the Bureau of Public Health Services were also present. The following recommendations emanated from the discussion and were approved by the Welfare Committee:

1. That copies of all future news releases issued by the State Department of Health be sent to the secretaries of the respective county medical societies.
2. That The Medical Society of New Jersey go on record, and this action be presented to the New Jersey State Department of Health, that the Society would like the Department of Health to distribute vaccine from state and federal sources to biological stations, that such vaccine be made available to physicians in their offices, and that the Health Department replenish the vaccine as fast as it is used.

Mental Hygiene—During the year a Special Study Group on Community Health Services was appointed within the committee and requested particularly to study mental health. The chairman of the study group, Dr. Edward P. Duffy, Jr., attended the A.M.A. Conference on Mental Health. He brought back several suggestions and resolutions for consideration. Action on these suggestions and recommendations was withheld until after the committee has had an opportunity to study them in conjunction with the remarks of the State Director of Mental Health, who appeared before the Welfare Committee in March and discussed the many phases of mental health which are of concern to his department and should be of concern to the medical profession and to the public. After the subcommittee has made its study, it will present its recommendations for a mental health program to the Welfare Committee for consideration. The subject of mental health is high on the agenda of the subcommittee for immediate study and action.

One specific recommendation adopted by the subcommittee was approved by the Welfare Committee. This resolved that all encouragement be given to medical, governmental, and lay organizations in their attempt to establish psychiatric units in all general hospitals.

Special Committees—The work of the Special Committees on Chronically Ill, Hearing and Speech, School Health, Routine Health Examination, and Vision has progressed during the year. The details of their work will be found in their individual reports.

SPECIAL COMMITTEES OF THE PUBLIC HEALTH COMMITTEE

Conservation of Hearing and Speech

(Reference Committee "E")

S. Eugene Dalton, M.D., Chairman, Ventnor City

The Special Committee on Conservation of Hearing and Speech (in cooperation with the New Jersey Society of Ophthalmology and Otolaryngology) held three meetings during the past year.

Their work has shown gratifying progress in establishing hearing and speech centers throughout the state. These centers, under the jurisdiction of recognized otolaryngologists, will help diagnose, care for, and coordinate the work for all defective hearing and speech patients in the state.

A special clinic for otolaryngologists and pediatricians was held in February 1956 on Conservation of Hearing and Speech at the Henry C. Barkhorn Memorial Center in Newark. It was a cardinal success and the beginning of a state wide movement to help the deaf and defective speech patients.

RECOMMENDATIONS

1. To activate the approved program of last year: establishing hearing and speech research centers in local hospitals in Trenton and Atlantic City to work with the Newark Center.

2. Establishment by county societies of committees for the conservation of hearing and speech to coordinate and effectuate at county level the program of the state committee.

3. More intimate cooperation between the Special Committee on the Conservation of Hearing and Speech and the Special Committee on School Health for the purpose of more fully realizing their respective objectives.

4. The State Motor Vehicle Department has established a clinic to examine individuals who have been involved in fatal accidents. It is suggested that these individuals be tested with the simple screening audiometer used in the public school system. As each new clinic is organized, it is suggested that a screening audiometer be installed and a technician trained to use it, under the supervision of an otologist. With this as a beginning, in a few years statistics thus obtained will act as a basis for further recommendations.

Conservation of Vision

(Reference Committee "E")

William J. McKeever, M.D., Chairman, Jersey City

This committee had two meetings during the year. There were no suggestions or problems brought to the attention of this committee, which acts in a purely advisory capacity. Therefore, we have nothing to report and no recommendations to make.

Routine Health Examination

(Reference Committee "E")

Robert E. Verdon, M.D., Chairman, Cliffside Park

The purpose of this committee is to develop a screening type of physical examination, to be done in the physician's office, which would be adequate to detect abnormalities and determine functional capacities where necessary. Such a pre-arranged method would, if followed, satisfactorily fill the needs of the patient as well as conserve time for the physician.

The complete examination, developed by the committee, is divided into three sections: (1) history, (2) laboratory procedures, and (3) physical examination. The history would be completed at home by the patient and submitted to the physician for study prior to the physical examination. The form suggested is a modification of the Cornell Index. We will submit this and other forms in the near future through the proper channels for approval, after which it is hoped they can be printed and made available—with or without charge— to those who wish to use them.

School Health

(Reference Committee "E")

Joseph R. Jehl, M.D., Chairman, Clifton

This committee continued the study of the problem of a uniform health program which was started last year. It considered the detailed workings of representative urban, suburban, and rural school districts. The variations are extreme, and the needs of various communities are believed to differ.

Since the Welfare Committee did not approve of the first plans in keeping with the report and recommendation of the School Health Committee of the American Academy of Pediatrics, further study was requested.

The committee submitted a program listing, in detail, the necessary requirements for the medical examiners to follow. We attempted in no way to restrict the more extensive activities being pursued in some communities. The Welfare Committee accepted this report.

Physicians Placement Service

(Reference Committee "D")

MARCUS H. GREIFINGER, M.D., Chairman, Newark

The Physicians Placement Service has continued its policy of listing physicians desiring locations in New Jersey, and information regarding communities in need of additional physicians. Summary reports containing all pertinent information have been prepared at three-month intervals and distributed to all interested parties who have communicated with the Placement Service.

In the past year, 176 physicians registered with the Placement Service. Of these, 58 had been directed to our office by the A.M.A. The other 118 applied directly by mail, telephone, or by personal visit. Twenty-four have located in New Jersey, 37 have located in other states. Fifty-three failed to acknowledge our follow-up communications. Sixty-three are now on the active list. Approximately 60 per cent of the physicians registering wish to specialize, while about 90 per cent of the vacancies indicate the desirability for general practitioners. Forty-seven communities were listed as areas in need of physicians. Four reported vacancies have been filled, and two new areas have been added to the original list for a total of 45 communities still seeking physicians.

Fifteen New Jersey physicians have utilized the facilities of the Physicians Placement Service in their search for assistants or associates. We have been advised by several of this group that the registrants quite frequently do not bother to acknowledge contacts made with them. Another service offered is one to members' widows who wish to dispose of equipment or practices. They are furnished with a list of the registrants with whom they can make direct contact.

All services connected with the Placement Service are provided without cost to the physicians or to the communities. The work is done by members of the office staff as part of their regular duties. The actual cost is small but the benefits derived by both physicians and communities are great.

Emergency Medical Service, Civil Defense

(Reference Committee "D")

R. WINFIELD BETTS, M.D., Chairman, Medford

The functions of this committee are purely advisory to the President and to the Board of Trustees. During the past year numerous requests have been made by the President related to Civil Defense effort. These requests have been answered promptly and completely.

Committee members attended the meeting of the Council on National Defense of the AMA in Atlantic City in June 1955 and the convention of the Association of Military Surgeons (a two-day symposium on disaster medicine) in Washington during November 1955. Full reports on these meetings were furnished to the President.

A round-table discussion with the Chairman, Civil Defense Committees of the component County Societies, and with the Medical Coordinators, Civil Defense-Disaster Control organizations, was held in October 1955. This was productive of many suggestions but, most important, it showed the wide divergence of opinion on responsibility between the private physician and the Medical Coordinators. Some method must be found to bridge the informational gap between these two groups. It is incumbent upon each physician in New Jersey to know his part in the State's Disaster Plan.

It is evident, from experience gained during previous civilian disasters in this country that traumatic surgery as regularly practiced in our hospitals, must be modified during

times of disaster. With this in mind, a symposium on disaster medicine has been planned for the coming convention.

To the committee it is more apparent each year that coordinated planning and preparation are lacking at all governmental levels. *If* Civil Defense is important much more has to be done about it at federal level. If it is *not* important, let's stop wasting time with it. The apparent remedial step is a Bureau of Civil Defense Disaster Control in the Department of Defense, with the Director on equal professional level with the Secretaries of the Departments of the Army, Navy, and Air Force.

RECOMMENDATIONS

1. That THE JOURNAL of The Medical Society of New Jersey be utilized to acquaint the physicians in this state with their part in disaster planning.

2. If the program on disaster medicine be a success at the coming Annual Meeting, our Medical Society should form teams of qualified speakers who may offer to the county societies scientific programs of essentially the same type as presented at the State convention.

3. That the following resolution be adopted by the House of Delegates:

Whereas: we are informed by the military that the next war in this "atomic age" will be directed against the civilian population as well as against military objectives; and

Whereas: the Government of the United States through the Civil Defense Administration has not made proper and adequate provision for the medical needs of the civilian population in the event of an attack of such magnitude; and

Whereas: the personnel, facilities and equipment already provided or contemplated can be used as readily in civil disaster caused by acts of God in our country as for catastrophy caused by enemy action; and

Whereas: the overall direction of rescue and relief efforts extending over many states is a matter for federal direction and transects state boundaries; and

Whereas: there is no federal agency at present directly charged with the protection or relief of the civilian population affected by such natural disasters;

Now Therefore Be It Resolved by the House of Delegates of The Medical Society of New Jersey that there be established a Department of Civil Defense Disaster Control in the Department of Defense of the United States; that the Director of this Department be given status equal to the status of the Directors of the Army, the Navy, or the Air Force; and that this Department of Civil Defense-Disaster Control be directly charged with the protection, rescue, and relief of the civilian population of this country from the effects of natural disaster as well as the effects of disaster resulting from enemy action.

Be It Further Resolved that a copy of this resolution be forwarded to the House of Delegates of the American Medical Association and that our Delegates to the American Medical Association be instructed to utilize their utmost endeavors in order that the American Medical Association make its voice heard to the Congress of the United States as a proponent of this plan.

Widows and Orphans of Medical Men

(Reference Committee "D")

ANTHONY G. MERENDINO, M.D., Chairman, Atlantic City

The Special Committee on Widows and Orphans of Medical Men had no occasion to meet during the year 1955-56.

Resolutions • • •

1955 Amendments to the Constitution and By-Laws

FROM THE UNION COUNTY MEDICAL SOCIETY

(Reference Committee on Constitution and By-Laws)

These resolutions are published here in the form submitted by the county societies and other sources.

PART I

Whereas at a regular meeting on May 22 the Board of Trustees invalidated the action of the House of Delegates on prior action taken by the House of Delegates at the 1955 meeting affecting amendments concerning the Board of Trustees and the Judicial Council set forth in a letter from the Board of Trustees to the component County Medical Societies on June 3, and invalidating the action of the House of Delegates for the following alleged reasons:

1. Because of lack of compliance with procedures set forth in Article XII of the Constitution and Chapter XV of the By-Laws which requires submission of all proposed amendments to a committee on revision of Constitution and By-Laws prior to introduction in the House.

2. Because of proposed amendments voted upon at the final session of the House wherein certain sections were substantially different than those read at the first session. Furthermore, the Board of Trustees acted to establish a committee on revision of Constitution and By-Laws to consist of three members of the Board with legal counsel of the State Society acting in an advisory capacity.

Furthermore, the Board of Trustees gave this committee power to submit only those proposed amendments which were in the form *approved* by the Committee on Revision of Constitution and By-Laws.

The final paragraph of the letter reads as follows:

"The Board by unanimous action further resolved that in the future proposed amendments of the Constitution and By-Laws must be received in the Executive Offices by March first for consideration of the Committee on Revision of Constitution and By-Laws in advance of the next annual meeting. It was further agreed that proposed amendments in the form *approved* by the Committee on Revision of Constitution and By-Laws should be published in the JOURNAL prior to the annual meeting."

And whereas under Chapter VII of the By-Laws entitled "Committees", Section II, "Standing Committees" there is no listing of a committee on revision of Constitution and By-Laws and no powers listed for such a committee. And whereas under Chapter VII, Section XIV, Reference Committees, it is stated as follows: "Immediately after the organization of the House of Delegates at each annual meeting, the President shall appoint from the members of the House, reference committees of five members each unless otherwise provided to serve during the session for which they are appointed. To these committees may be referred any reports, resolutions, measures or propositions which have been presented to the House. When a matter is referred to any committee, it shall meet forthwith to discuss the question referred and debate thereon by any interested member of the society and shall submit its *recommendations* at the next session of the House for action."

And whereas the Constitution provides the following:

Under Section XV—Names of Reference Committees:

C. Constitution and By-Laws Committee—

And whereas under Article XII of the Constitution entitled "Amendments" there is an ambiguous reference to a committee on revision of the Constitution and By-Laws. And in Chapter XV of the By-Laws entitled "Amendments" there is also this same ambiguous reference to a committee on Constitution and By-Laws. And whereas there is no other reference to this committee on Constitution and By-Laws and no other provision in the Constitution or By-Laws for such a committee.

And whereas by tradition and usage, the Reference Committee on Constitution and By-Laws has always been used and considered to be this committee on Constitution and By-Laws.

And whereas a third amendment in regard to honorary membership was apparently considered to be constitutional by the Board of Trustees.

And whereas this amendment on honorary membership has been processed only by the Reference Committee on Constitution and By-Laws and whereas all other amendments to the Constitution had been processed only by this Reference Committee on Constitution and By-Laws.

And whereas no other amendment has been invalidated on the grounds stated by the Board of Trustees because of not being reviewed by the proper committee.

And whereas under Section XIV herein mentioned, it is stated that the Reference Committee on Constitution and By-Laws shall submit its recommendations; and whereas there is no qualification as to these recommendations, except that it is assumed by tradition and usage, the Reference Committee will not change or alter the original subject or intent of the matter which has been referred to it.

Therefore be it resolved that there is no constitutional authority for the Board of Trustees to establish a Committee on Revision of Constitution and By-Laws with the power to censure, approve or disapprove any amendment properly submitted to amend the Constitution or By-Laws. And that any requirement that a proposed amendment must be approved by a Committee on Constitution and By-Laws is declared void by the House of Delegates.

Be it further resolved that the Reference Committee on Constitution and By-Laws has been by tradition and usage the committee to which amendments have been submitted and that the House of Delegates resolve that the Reference Committee on Constitution and By-Laws is the proper Committee to which proposed amendments to the Constitution and By-Laws shall be submitted according to the Constitution

PART II

And whereas under Article XII of the Constitution entitled "Amendments", the following is stated: "This Constitution may be amended by a two-thirds vote of the members present at any annual meeting, provided the proposed amendments have been considered by the Committee on Revision of Constitution and By-Laws, and that they shall have been submitted in writing at a previous annual meeting and have been published in the JOURNAL of this society and officially sent to each component society at least three months before the annual meeting at which final action is to be taken."

And whereas the proposed amendment to Article VI entitled "The Board of Trustees" was introduced by the delegation from Mercer County on the first day of the meeting of the House of Delegates,

And whereas this amendment was referred to the Reference Committee on Constitution and By-Laws,

And whereas the Reference Committee submitted its recommendations at the third meeting of the House of Delegates and did not change the intent or objective of the original proposal,

And whereas the Reference Committee did recommend the addition of a paragraph setting up the mechanism of electing the Board of Trustees.

And whereas both of these recommendations of the Reference Committee were passed by the required two-thirds majority of the House of Delegates.

And whereas this amendment to the Constitution according to Article XII of the Constitution has been submitted at a previous annual meeting and has been officially published in the JOURNAL of The Medical Society of New Jersey and sent to each component society at least three months before the annual meeting. Therefore, the meeting at which this final action is to be taken is construed to be the present meeting of the House of Delegates.

And whereas the publication of the amendment and the sending of the amendment to each component society is to take place before the final action and not before the first reading.

A. Therefore, be it further resolved that the amendment proposed by Mercer County to Article VI entitled: "Board of Trustees" of the Constitution has been properly submitted in writing at a previous annual meeting.

B. Has been considered by the proper Reference Committee on Constitution and By-Laws.

C. Has been published in the JOURNAL of The Medical Society of New Jersey.

D. And has been sent to each component society at least three months prior to the final annual meeting at which action is taken.

1. Therefore be it further resolved that the House of Delegates declare that the proper constitutional procedure has been followed in

regard to this amendment entitled "The Board of Trustees".

2. And that this amendment entitled "The Board of Trustees" shall be submitted for final action at this meeting of the House of Delegates.

PART III

And whereas Chapter XV of the By-Laws entitled "Amendment" states as follows:

"These By-Laws may be amended at any annual meeting of The Medical Society of New Jersey by a two-thirds vote of the members present provided that at least fifty members are present; and provided further, that the amendment shall have been submitted to the Committee on Constitution and By-Laws and shall have been read twice at an open meeting and laid upon the table for one day."

And whereas this amendment to the By-Laws entitled "Judicial Council" was introduced at the first meeting of the House of Delegates and on motion by Dr. Dilger, and approved by the House of Delegates, the publications submitted in the folder were construed as the necessary readings.

And whereas the By-Laws were submitted to the Reference Committee on Constitution and By-Laws.

And whereas the Committee on Constitution and By-Laws submitted its recommendations to the House of Delegates at the third session.

And whereas the proposed amendment was laid on the table for one day,

And whereas the recommendations of the Committee on Revision of Constitution and By-Laws were approved by a necessary two-thirds majority of the House of Delegates.

A. Therefore, be it further resolved that the amendment to Chapter VII of the By-Laws entitled: "Judicial Council" was properly read at the first meeting of the House of Delegates.

B. Was laid on the table for one day.

C. Was considered by the Reference Committee on Constitution and By-Laws.

D. Was submitted at the final meeting of the House of Delegates by the Reference Committee on Constitution and By-Laws.

E. And that the amendment together with the recommendations of the Reference Committee on Constitution and By-Laws was approved by the necessary two-thirds vote of the House of Delegates.

Therefore, be it further resolved that the House of Delegates declare that this amendment to the By-Laws entitled "Judicial Council" is properly in effect as of the annual meeting of the House of Delegates in 1955.

PART IV

And whereas under By-Laws, Chapter V, Duties of Officers, Section V, Paragraph B. entitled "Powers", the Board of Trustees is in no wise given the authority or the power to void any action of the House of Delegates with or without the advice of counsel.

Therefore be it resolved that the Board of Trustees exceeded the Board's constitutional powers when the Board declared illegal the action of the House of Delegates in regard to amendments to the Constitution and By-Laws, and that the House of Delegates declares this action of the Board of Trustees to be void.

Medical-Surgical Plan Contract Changes

FROM THE MERCER COUNTY MEDICAL SOCIETY

(Reference Committee "C")

Whereas the individual members of The Medical Society of New Jersey have a vital interest in the actual contracts of the Medical-Surgical Plan of New Jersey, and

Whereas various changes are proposed in this contract from time to time and from many sources, and

Whereas the Board of Trustees of the Medical-Surgical Plan of New Jersey presents these proposals to the House of Delegates of The Medical Society of New Jersey at its annual meeting without previous study by the members of the Society or the delegates or their committees.

Therefore be it resolved that any basic change in the contract of the Medical-Surgical Plan of New Jersey be effected in the following manner:

1. That the details of the contemplated basic changes be in the hands of the Board of Trustees of The Medical Society of New Jersey at least three (3) months before the meeting of the House of Delegates.
2. That a supplementary report be in the hands of the chairman of the proper reference committee and of its members one (1) month before the Annual Meeting of The Medical Society of New Jersey.
3. That following the action of the Board of Trustees, the findings of this Board and/or the details of the contemplated basic changes in the contract of the Medical-Surgical Plan of New Jersey, be published in the JOURNAL of The Medical Society of New Jersey, in the issue at least one (1) month prior to the Annual Meeting, for the information of all of the members of the Society.

Apportionment of Fees by Medical-Surgical Plan

FROM THE MERCER COUNTY MEDICAL SOCIETY

(Reference Committee "C")

Whereas the 1955 House of Delegates of The Medical Society of New Jersey approved payment for surgical assistance within a range of $10 - $30, and

Whereas this approval was in anticipation of a new contract to be issued in 1956, and

Whereas this payment was for surgical assistance only.

Therefore be it resolved that the Mercer County Component Medical Society disapprove the action of the Board of Trustees of The Medical-Surgical Plan of New Jersey, and disapprove the supporting action taken by the Board of Trustees of The Medical Society of New Jersey in approving an increase in apportionment of fees to a maximum of $50 for surgical assistance, and

Be it further resolved that the Mercer County Component Medical Society vehemently disapproves the apportionment of the surgical fee for pre- and post-operative care without limitation to surgical assistance.

Income Limitation of Medical-Surgical Plan Contract

FROM THE MERCER COUNTY MEDICAL SOCIETY

(Reference Committee "C")

Whereas the Board of Trustees of the Medical-Surgical Plan of New Jersey requests The Medical Society of New Jersey to approve a proposed contract change which is entirely apart from and supplementary to those changes approved by the House of Delegates of The Medical Society of New Jersey in May, 1955, namely:

"(a) That the $5,000 limitation be continued with respect to single person Contracts.

(b) That the income limitation with respect to all other Contracts be $7,500, but include the joint income of Subscriber and spouse, if any."

Whereas this change is to be effected prior to the meeting of and without the approval of the House of Delegates of The Medical Society of New Jersey.

Therefore be it resolved that the Mercer County Component Medical Society disapproves this change, and is opposed, in principle, to any basic change in the contract without the prior approval of the House of Delegates of The Medical Society of New Jersey.

Hospital Service Plan Medical Services

(Reference Committee "C")

FROM THE BERGEN COUNTY MEDICAL SOCIETY

Whereas, it is evident that payments of certain medical services are now incorporated in Blue Cross Hospitalization Plan of New Jersey contracts for direct payment to the subscribing hospitals, and

Whereas, this concept is foreign not only to our ethical principles, but also to those of the American Medical Association;

Be it resolved, that the Bergen County Medical Society go on record as demanding the deletion of such payments for medical services from the Blue Cross Hospitalization Plan of New Jersey and any other statement in the Blue Cross contract implying coverage of medical services; and that such services be included in the Blue Shield Medical-Surgical Plan of New Jersey.

Be it further resolved, that if the medical services now supplied by hospitals under Blue Cross are removed and added to the Blue Shield contract, no restrictive clauses as to who may render these services may be made, used, or employed in the Blue Shield contract.

Be it further resolved, that a copy of this resolution be sent to the State Medical Society of New Jersey for appropriate action.

FROM THE CAMDEN COUNTY MEDICAL SOCIETY

Whereas, it is evident that payments of certain medical services are now incorporated in Blue Cross Hospitalization Plan of New Jersey contracts for direct payment to the subscribing hospitals, and

Whereas, this concept is foreign not only to our ethical principles, but also to those of the American Medical Association,

Be it resolved, that the Camden County Medical Society go on record as demanding deletion of such payments for medical services from the Blue Cross Hospitalization Plan of New Jersey and any other statement in the Blue Cross contract implying coverage of medical services; and that such services be included in the Blue Shield Medical-Surgical Plan of New Jersey.

Be it further resolved that a copy of this resolution be sent to the State Medical Society of New Jersey for appropriate action.

FROM THE ESSEX COUNTY MEDICAL SOCIETY

Whereas, it is evident that payments of certain medical services are now incorporated in the Hospital Service Plan of New Jersey (Blue Cross) contracts for direct payment to the subscribing hospitals, and

Whereas, this concept is foreign not only to our ethical principles, but also to those of the American Medical Association,

Be it resolved, that the Essex County Medical Society go on record as demanding the deletion of such payments for medical services from the Hospital Service Plan of New Jersey (Blue Cross) and any other statement in the Blue Cross contract implying coverage of medical services; and that such services be included in the Medical-Surgical Plan of New Jersey (Blue Shield).

Be it further resolved that a copy of this resolution be sent to The Medical Society of New Jersey for appropriate action.

FROM THE HUDSON COUNTY MEDICAL SOCIETY

Whereas, it is evident that payments of certain medical services are now incorporated in Blue Cross Hospitalization Plan of New Jersey contracts for direct payment to the subscribing hospitals, and

Whereas, this concept is foreign not only to our ethical principles, but also to those of the American Medical Association,

Be it resolved, that the Hudson County Medical Society go on record as requesting the deletion of such payments for medical services from the Blue Cross Hospitalization Plan of New Jersey and deletion of any other statement in the Blue Cross contract implying coverage of medical services; and that such medical services be included in the Blue Shield Medical-Surgical Plan of New Jersey.

Be it further resolved, that a copy of this resolution be sent to The Medical Society of New Jersey for appropriate action.

FROM THE HUNTERDON COUNTY MEDICAL SOCIETY

Whereas, it is evident that payments of certain medical services are now incorporated in Blue Cross Hospitalization Plan of New Jersey contracts for direct payment to the subscribing hospitals, and

Whereas, this concept is foreign not only to our ethical principles, but also to those of the American Medical Association,

Be it resolved, that the Hunterdon County Medical Society go on record as demanding the deletion of such payments for medical services from the Blue Cross Hospitalization Plan of New Jersey and any other statement in the Blue Cross contract implying coverage of medical services; and that such services be included in the Blue Shield Medical-Surgical Plan of New Jersey.

Be it further resolved that a copy of this resolution be sent to the State Medical Society of New Jersey for appropriate action.

FROM THE MERCER COUNTY MEDICAL SOCIETY

Whereas, it is evident that payments of certain medical services are now incorporated in Blue Cross Hospitalization Plan of New Jersey contracts for direct payment to the subscribing hospitals, and

Whereas, this concept is foreign not only to our ethical principles, but also to those of the American Medical Association,

Be it resolved, that the Mercer County Component Medical Society go on record as demanding the deletion of such payments for medical services from the Blue Cross Hospitalization Plan of New Jersey and any other statement in the Blue Cross contract implying coverage of medical services; and that such services be included in the Blue Shield Medical-Surgical Plan of New Jersey.

Be it further resolved that a copy of this resolution be sent to the State Medical Society of New Jersey for appropriate action.

FROM THE MONMOUTH COUNTY MEDICAL SOCIETY

Whereas, it is evident that payments of certain medical services are now incorporated in Blue Cross Hospitalization Plan of New Jersey contracts for direct payment to the subscribing hospitals, and

Whereas, this concept is foreign not only

to our ethical principles, but also to those of the American Medical Association

Be it resolved, that the Monmouth County Medical Society go on record as recommending the deletion of such payments for medical services from the Blue Cross Hospitalization Plan of New Jersey and any other statement in the Blue Cross contract implying coverage of medical services; and that such services be included in the Blue Shield Medical-Surgical Plan of New Jersey

Be it further resolved, that a copy of this resolution be sent to the State Medical Society of New Jersey for appropriate action.

FROM THE SALEM COUNTY MEDICAL SOCIETY

Whereas, it is evident that payments for certain professional medical services are now incorporated in Blue Cross contracts for direct payment to the subscribing hospitals; and

Whereas this concept is foreign not only to our ethical principles but also to those of the American Medical Association;

Be it resolved that this County Society go on record as requesting the deletion of such payments for medical services from the Blue Cross Contract, as well as any statement implying coverage of medical services, and that such payments be incorporated in our Blue Shield Plan; and

Be it further resolved that a copy of this resolution be forwarded to the various county societies and to The Medical Society of New Jersey for appropriate consideration and action.

FROM THE SOMERSET COUNTY MEDICAL SOCIETY

Whereas, it is evident that payments for certain medical services are now incorporated in the Blue Cross Hospitalization Plan of N. J., contract for direct payment to the subscribing hospitals, and,

Whereas, this concept is foreign not only to our ethical principles but also to those of the A.M.A.,

Be it Resolved, that the Somerset County Medical Society go on record as recommending the deletion of such payments for medical services from the Blue Cross Hospitalization Plan of N. J. and any other statements in the Blue Cross contract implying coverage of medical services; and that such services be included in the Blue Shield Medical Surgical Plan of N. J.

Be it Further Resolved, that a copy of this resolution be sent to the State Medical Society of N. J. for appropriate action.

FROM THE UNION COUNTY MEDICAL SOCIETY

Whereas, it is evident that payments for certain professional medical services are now incorporated in Blue Cross contracts for direct payment to the subscribing hospitals; and

Whereas this concept is foreign not only to our ethical principles, but also to those of the American Medical Association;

Be it resolved that this County Society go on record as demanding the deletion of such payments for medical services from Blue Cross Contract, as well as any statement implying coverage of medical services, and that such payments be incorporated in our Blue Shield Medical-Surgical Plan; and

Be it further resolved that a copy of this resolution be forwarded to the various county societies and to The Medical Society of New Jersey for appropriate consideration and action.

Amendments to the Constitution and By-Laws • • •

These amendments are published here in the form as submitted by the county societies and other sources.

(Reference Committee on Constitution and By-Laws)

ARTICLE VI—BOARD OF TRUSTEES

FROM THE UNION COUNTY MEDICAL SOCIETY

Delete Article VI of the Constitution and replace Article VI with this amendment:

Section 1. The Board of Trustees shall be the executive body. It shall be composed of the immediate Past-President, President, President-Elect, two (2) Vice-Presidents, Secretary, and Treasurer (by virtue of their offices), and twenty-one (21) members. Each member shall be elected from and by his component county society prior to the annual meeting of the House of Delegates. Each member shall be elected for a term of three (3) years, such term to commence upon the expiration of the term of the former incumbent. The term of office of seven members shall expire annually.

Section 2. Provided that at first election following the adoptions of these amendments, the first seven (7) counties alphabetically, from Atlantic through Essex, shall elect for one (1) year, the second seven (7) counties, from Gloucester through Morris, for two (2) years, and the third seven (7) counties, from Ocean through Warren, shall elect for three (3) years. Thereafter, at the expiration of those terms each Trustee shall be elected for three (3) years. After two (2) years Article VI, Section 2 shall be automatically deleted from the Constitution without further amendment.

Section 3. Any member as classified in Article VI, Section 1, may be elected a Trustee for a maximum of three (3) full terms provided however that if the first two (2) elected terms are successive there shall be a lapse of at least one (1) year between expiration of the second and commencement of the third terms.

Section 4. In the event that the office of any member becomes vacant for any reason the component county society wherein the vacancy exists shall elect a member within 90 days to fill the unexpired term.

ARTICLE VI—BOARD OF TRUSTEES

FROM THE MERCER COUNTY MEDICAL SOCIETY

Whereas, The present method of election of members of the Board of Trustees of The Medical Society of New Jersey gives many county societies of the state no representation.

Whereas, The approval of the following resolution will give a more equitable representation to all the county societies of the state, hence giving that body a relationship to the House of Delegates similarly enjoyed by the New Jersey State Senate in its relationship to the Assembly.

Whereas, The Board of Trustees would continue to exert its beneficent control, but more effectively, and would make it possible for each county society to be heard in all important matters of state policy.

Whereas, Since the present board consists of approximately eighteen members, the addition of a few more to its membership will cause no great inconvenience.

Therefore be it resolved, That Article VI—Board of Trustees read as follows:

Section 1. The Board of Trustees shall be the executive body and shall be composed of the immediate Past-President, President, President-Elect, two (2) Vice-Presidents, Secretary and Treasurer (by virtue of their offices), and twenty-one (21) members, each member elected from and by his component county society prior to the annual meeting of the House of Delegates, which twenty-one (21) members shall each be elected for a term of three (3) years, such term to commence upon the expiration of the term of the former incumbent.

Section 2. Provided that at the first election the first seven (7) counties alphabetically, from Atlantic through Essex, shall elect for one (1) year, the second seven (7) counties, from Gloucester through Morris for two (2) years, and the third seven (7) counties, from Ocean through Warren, shall elect for three (3) years. Thereafter at the expiration of these terms each Trustee shall be elected for three (3) years. After two (2) years Article VI, Section 2, shall be automatically deleted from the Constitution without further amendment.

Section 3. Any member as classified in Article VI, Section 1, may be elected a Trustee for a maximum of three (3) full terms provided however that if the first two (2) elected terms are successive there shall be a lapse of at least one (1) year between expiration of the second and commencement of the third terms.

Section 4. In the event of death or inability, due to prolonged illness, of a Trustee elected by the county society, to represent his county, the county society president be privileged to appoint an active member of the county society to complete the unexpired term of office.

ARTICLE XII—AMENDMENT TO THE CONSTITUTION AND BY-LAWS

FROM THE UNION COUNTY MEDICAL SOCIETY

Delete Article XII of the Constitution and replace Article XII with this amendment:

Section 1—Amendments to the Constitution or By-Laws may be introduced by an officer or committee of The Medical Society of New Jersey or by any component County Medical Society provided that:

1. The proposed amendment to the Constitution or By-Laws shall be submitted in writing to each component County Medical Society at least sixty days prior to the annual meeting of the House of Delegates.

2. The proposed amendment to the Constitution or By-Laws shall be published in the JOURNAL of The Medical Society of New Jersey at least sixty days prior to the annual meeting of the House of Delegates.

3. The proposed amendment to the Constitution or By-Laws shall be submitted and read to the House of Delegates at its first meeting.

4. The proposed amendment to the Constitution or By-Laws shall then be submitted to the Reference Committee on Constitution and By-Laws.

5. The proposed amendment to the Constitution or By-Laws shall be submitted by the Reference Committee on Constitution and By-Laws together with the recommendation of the commitee for action at the third meeting of the House of Delegates.

6. The recommendation by the Reference Committee on Constitution and By-Laws for any changes, additions, or rephrasing of the original proposed amendment to the Constitution or By-Laws shall be introduced by the chairman of the committee at the third meeting of the House of Delegates as amendments to the original amendment and must first be approved by a two-thirds vote of the members present at the meeting of the House of Delegates.

7. For affirmative action the proposed amendment or the proposed amendment as amended to the Constitution or By-Laws shall be approved by a two-third affirmative vote of the members present at the meeting of the House of Delegates.

8. The proposed amendment to the Constitution or By-Laws shall be submitted to the Secretary of each component County Medical Society immediately following the meeting of the House of Delegates.

9. The proposed amendments to the Constitution or By-Laws shall be introduced and read by each component County Medical So-

ciety at the regular meeting of the component County Society next following the meeting of the House of Delegates.

10. Each component County Medical Society shall vote on the amendment to the Constitution or By-Laws at its second regular meeting following the meeting of the House of Delegates. An affirmative vote by two-thirds of the members present at the County meeting shall be required for favorable action, provided a quorum is present. The Component County Medical Society must vote on the proposed amendment as submitted by the House of Delegates with no changes, deletions, additions or rephrasing.

11. The result of the vote of each component County Medical Society shall be immediately submitted to the Board of Trustees of The Medical Society of New Jersey. An affirmative vote by fourteen members of the component County Medical Societies shall make the amendment or By-Law immediately effective. The Secretary of The Medical Society of New Jersey shall immediately submit a report of the vote by Counties to all members of the component County Medical Societies.

12. A proposed amendment to the Constitution or By-Laws may be introduced at the first meeting of the House of Delegates, omitting procedures one and two under Article XII. It shall be laid on the table without action until the next annual meeting of the House of Delegates when it shall be considered under procedures—three, four, five, six, seven, eight, nine, ten, eleven under Article XII.

CHAPTER V—SELECTION OF OFFICERS

FROM THE UNION COUNTY MEDICAL SOCIETY

Delete Chapter V, Section 1, 2, 3, 4, 5, and replace Chapter V, Section 1, 2, 3, 4, 5, with this amendment insert:

Section 1—Nominating Committee

A. The Nominating Committee shall consist of one member and an alternate from each component County Medical Society. The members and an alternate shall be elected for a period of one year from among the elected delegates of the component county society at its annual meeting. The names of the members of the Nominating Committee and the alternates shall be recorded with the Secretary of The Medical Society of New Jersey. At the time of its meeting, the Nominating Committee shall elect a chairman and secretary.

Section 2—Meeting of the Nominating Committee

A. The meeting of the Nominating Committee shall be called by the President of The Medical Society of New Jersey on a Sunday at 2:00 p.m. not less than sixty days and not more than ninety days prior to the annual meeting of the House of Delegates. The meeting shall be at a centrally located area of the State. Notice of the date and place shall be submitted to each component County Medical Society not later than thirty days prior to the meeting date. Fourteen members shall constitute a quorum.

B. The secretary of The Medical Society of New Jersey shall furnish each component County Medical Society with a list of the offices, committees, or delegates to be elected at the next meeting of the House of Delegates not later than the first day of December.

Section 3—Procedure of Nomination

A. The secretary of the society shall furnish to the Nominating Committee such information as is necessary for the proper conduct of its business.

B. Each component County Medical Society may place in nomination one candidate for each office, committee, or delegate to be elected provided that the nominations be in writing and that the candidate has been approved by the component County Medical Society by affirmative majority vote of its members present at a regular meeting. This must be certified by the members of the Nominating Committee at the time the candidate is placed in nomination. This shall constitute the formal nomination of the candidate.

C. In the event that no candidate for any office, committee or delegate is placed in nomination by any component County Medical Society, the Nominating Committee shall select one or more nominees for each office, committee or delegate by majority vote of the Committee.

D. All nominations shall be made at the

meeting of the Nominating Committee. There shall be no subsequent nomination from the floor at the meeting of the House of Delegates except where only one candidate has been nominated and the candidate has withdrawn his nomination and a vacancy exists for any reason. In the instance that there is no nominee at the time of election nominations shall be made from the floor of the House of Delegates.

Section 4—Record of Nominations

A. The secretary of the Nominating Committee shall record the list of names of the members or alternates present at the meeting of the Nominating Committee. This list shall be forwarded immediately to the secretary of The Medical Society of New Jersey.

B. The secretary of the Nominating Committee with the aid of the Nominating Committee shall compile a list of the candidates placed in nomination for each office, committee, or delegate. This slate of nominees shall be forwarded immediately to the secretary of The Medical Society of New Jersey by the chairman.

C. The secretary of The Medical Society of New Jersey shall forward a list of the candidates placed in nomination to each component County Medical Society within ten days following the meeting of the Nominating Committee. This list of candidates shall be published in the JOURNAL of The Medical Society of New Jersey.

Section 5—Election of Officers, Committees, and Delegates

A. The first election of officers, committees, and delegates shall be by written ballot during the first meeting of the House of Delegates. The second election shall be the first order of business of The Medical Society of New Jersey at the time of the second meeting of the House of Delegates. Voting may be by written ballot, voice vote, or division of the assembly.

B. Any nominee receiving a majority of the votes cast at the first or second election shall be considered elected.

C. Upon registration at the annual meeting each delegate, or an authorized alternate shall be issued a sealed envelope containing the official ballot. At the first meeting of the House of Delegates, four ballot boxes shall be provided within the confines of the assembly hall. Ballot boxes shall be open from the official opening of the meeting until one half hour after the adjournment of the first meeting of the House of Delegates. Each ballot box shall be supervised by two tellers, who are not nominees, appointed by the presiding officer. After the voting has closed the results shall be tabulated by the tellers and sent to the chairman of the Nominating Committee. The chairman of the Nominating Committee shall forward immediately the official results to the secretary of The Medical Society of New Jersey, and make the official results available at the registration desk for each county delegation.

D. It shall be the responsibility of the chairman of the Nominating Committee and secretary of The Medical Society of New Jersey to prepare suitable official ballots for use at the second meeting of the House of Delegates.

E. If no candidate for an office, committee, or delegate receives a majority vote on the first ballot, then the two candidates receiving the highest number of votes for each office on the first ballot shall be presented to the House of Delegates for the second election at the second meeting of the House of Delegates.

F. The election of the Trustees shall conform to the provision of Article VI of the Constitution.

G. The elected candidates shall be introduced individually to the House of Delegates.

H. Term of office remains the same.

CHAPTER VI—DUTIES OF OFFICERS

FROM THE MERCER COUNTY MEDICAL SOCIETY

Section 5—Board of Trustees

On line 12, delete "9" and revise to read "14" members shall constitute a quorum.

CHAPTER VI—DUTIES OF OFFICERS

FROM THE UNION COUNTY MEDICAL SOCIETY

Section 5—Board of Trustees

On line 12, delete "9" and revise to read "14" members shall constitute a quorum.

CHAPTER VII—JUDICIAL COUNCIL

FROM THE JUDICIAL COUNCIL

Amend present Chapter VII, Sections 1 through 10, to read as follows:

Section 1—Election

The Councilors (see also Constitution, Article VII) shall be elected as follows: At the first election of officers following the adoption of these by-laws, two (2) members shall be elected for a period of three (3) years; two (2) members for a period of two (2) years; and one (1) for a period of one (1) year; and as the terms of these elected Councilors expire new elections shall be for periods of three (3) years.

Section 2—Councilors

The Councilors collectively, shall be known as the Judicial Council, and shall constitute the supreme judicial body of the Society.

Section 3—Meetings

The Judicial Council shall meet as soon after the annual meeting of the House of Delegates as is convenient for the purpose of reorganization. Thereafter, the Judicial Council shall meet as often as may be necessary to transact its business at the call of the chairman or at the request of any three Councilors. Three members shall constitute a quorum.

Section 4—Duties of the Judicial Council

The duties of the Judicial Council shall be as follows:

1. To sit as an appellate tribunal and to hear and determine any and all appeals properly brought before it from any County Judicial Committee;
2. To interpret and rule upon all questions of an ethical nature that shall confront the House of Delegates or any other board or committee of the Society;
3. To adjudicate all disputes or controversies arising within The Medical Society of New Jersey;
4. To receive complaints or accusations from any source concerning the professional conduct or ethical deportment of members of this Society for immediate reference to the appropriate County Judicial Committee;
5. To receive, consider and rule on any matter of discipline concerning any member or members of the Society brought to it on appeal from a County Judicial Committee;
6. To make and promulgate from time to time such rules and regulations as in its opinion may be necessary to insure the proper functioning of the Judicial Council and the various County Judicial Committees with reference both to the substance and procedure of hearings had by the Judicial Council and such County Judicial Committees. Upon receipt of such rules and regulations by the various County Judicial Committees, the members of said committees shall be bound thereby.

Section 5—Procedure for Considering Grievances

Any complaint, allegation or grievance concerning a member or members of the Society, when received by the Judicial Council, shall be referred immediately to the chairman of the Judicial Committee of the county wherein the dispute or controversy arose, for appropriate action in accordance with the recommended uniform by-laws promulgated by the Judicial Council governing County Judicial Committees. The County Judicial Committees of the various component societies shall have exclusive original jurisdiction over all complaints against a member of any component society or between members of the same or different component societies. In the event that any controversy arises between members of different component societies, the matter shall be referred to a joint committee comprised of the members of the County Judicial Committees of the counties involved. An impartial chairman of such joint committee shall be designated by the Judicial Council to preside at the hearing, and he shall not be a member of either of the county medical societies involved.

If the County Judicial Committee or the joint County Judicial Committee shall find after hearing that a complaint, allegation, or grievance involves a matter which, in its opinion, would empower the State Board of Medical Examiners to revoke or suspend the license of a practitioner, it shall be the duty of such committee forthwith, by written complaint, to refer the findings to the Judicial Council, which shall in turn refer the complaint to the appropriate law enforcement agency or the State Board of Medical Examiners.

Section 6—Special Procedure for Complaints Involving Fees for Professional Services

In a complaint involving the just or proper amount of a fee for professional services, the County Judicial Committee shall first investigate and attempt to effect an amicable settlement. If it shall be unable to reconcile the differences between the parties, then it may determine the fee which it considers just and proper under all the circumstances of the

particular case, stating in writing the basis on which the fee has been determined.

If the Society member against whom the complaint is brought shall agree to abide by the decision of the County Judicial Committee and shall register this agreement with the complainant in a form to be prescribed for this purpose, then the case shall be considered closed and a report shall be rendered by the chairman to the Judicial Council.

If, however, the member should agree to the amount of the fee so fixed but fail to abide by his agreement, then the County Judicial Committee shall cite such a member for contempt and take appropriate action thereon.

If a member fails to accept the determination of the County Judicial Committee as to a just and proper fee, the committee shall then proceed in accordance with the recommended uniform by-laws herinabove referred to in Section 5.

Section 7—Appeals

Any member of a component county society aggrieved by an action of the County Judicial Committee, or any applicant for membership who has been excluded from membership by a county society, or any lay person aggrieved by an action of the County Judicial Committee may appeal from the decision or action of the county society or the County Judicial Commitee to the Judicial Council.

Decision of the said Judicial Council in any matter so appealed shall be final, except that further appeal may be taken by either party to the Judicial Council of the American Medical Association, if the subject of the dispute falls within the jurisdiction of that Council.

Any appeal to the Judicial Council of The Medical Society of New Jersey must be filed with the Judicial Council within forty-five (45) days of the date of the formal notice to the aggrieved party of the action of the component society or of the County Judicial Committee.

Form of notice of appeal and procedure in hearing and adjudication of same shall be in accordance with rules of procedure to be established by the Judicial Council, which shall be made available to the parties involved.

Upon filing a notice of appeal, the appellant and the component society or County Judicial Committee will be required to submit to the Judicial Council all records and papers relative to the matter under appeal. All such papers shall be treated confidentially by the Judicial Council and shall be returned at the completion of the hearing.

The Judicial Council may affirm, modify, or reverse, by a majority vote of its members present and voting, the appealed decision. The Judicial Council may summon witnesses, take new evidence, and investigate the appealed matter in any manner in its opinion required to develop the information necessary for a proper decision.

Section 8—Administration and Procedure

The administrative and legal costs of the operation of the Judicial Council shall be underwritten by The Medical Society of New Jersey in accordance with an annual appropriation for these purposes to be approved by the House of Delegates.

Every matter coming before the Judicial Council shall be considered in executive session. Its records shall be subject to inspection exclusively by members of the Council and by legal counsel for the Society. Except for purposes of consultation or testimony, no member or officer of the Society—save legal counsel, the executive officer of The Medical Society of New Jersey, and a stenographer, when their presence is deemed advisable by the members of the Council — shall be present at a meeting of the Council when any appeal or other matter is under consideration.

In pursuance of its investigatory and judicial functions, the Judicial Council shall have authority to summon members of the Society to appear and testify, either in connection with the complaint involving the member summoned, or as witnesses in cases involving other members. Should any member fail to respond to such a summons, the Judicial Council shall be, and hereby is, authorized to cite such a member to his component society for contempt. Such a citation shall be considered equivalent to a charge of unethical conduct and shall be dealt with by the County Judicial Committee in accordance with the provisions of the recommended uniform by-laws of said committees herein referred to.

The Judicial Council shall make, publish, and from time to time, in its discretion, revise and amend rules and regulations relating to procedure before County Judicial Committees and on appeal. Such rules and regulations shall specify periods of notice, procedure for disposition of complaints against physicians who are not members of the Society, procedures for notification to complainants and defendants, the nature of the charges advanced, maintenance of proper records, and such other rules as may be deemed necessary and proper.

Section 9—Penalties

The Judicial Council, following an appeal hearing, may either confirm, modify, or reverse the findings of a County Judicial Committee. Every County Judicial Committee shall have the power to censure, suspend, or expel any member of its society for just cause.

CHAPTER VII—JUDICIAL COUNCIL

FROM THE UNION COUNTY MEDICAL SOCIETY

Delete Chapter VII of the By-Laws and replace Chapter VII with this amendment:

Section 1—Election

The Councilors shall be elected as follows: At the first election of Officers following the adoption of these By-Laws two (2) members shall be elected for a period of three (3) years, two (2) members for a period of two (2) years, and one (1) member for a period of one (1) year, and as the terms of these elected councilors expire new elections shall be for a period of three (3) years.

Section 2—Councilors

The Councilors collectively shall be known as the Judicial Council and shall constitute the supreme Judicial body of the Society.

Section 3—Meeting

The Judicial Council shall meet immediately following the election of officers for the purpose of organization. Thereafter, the Judicial Council shall meet as often as may be necessary to transact its business at the call of the chairman. Three (3) members shall constitute a quorum.

Section 4—Duties of the Judicial Council

The duties of the Judicial Council shall be as follows:

1. To act as an appellate tribunal and to hear and determine any and all appeals properly brought before it from any County Judical Committee.
2. To interpret and rule upon all questions of an ethical nature that shall confront the House of Delegates or any other board or committee of the society.
3. To adjudicate all disputes or controversies arising within The Medical Society of New Jersey.
4. To receive complaints or accusations from any source concerning the professional conduct or ethical deportment of members of this society for immediate reference to the appropriate County Judicial Committee.
5. To receive, consider, and rule on any matter of discipline concerning any member or members of the society brought to the Judicial Council on appeal from a County Judicial Committee.

Section 5—Procedure for Considering Grievances

1A. Any complaint, allegations or grievance concerning a member of the society when received by the Judicial Council shall be referred immediately to the chairman of the County Judicial Committee wherein the dispute arose for appropriate action in accordance with the recommended uniform procedures promulgated by the Judicial Council governing County Judicial Committees.

1B. The County Judicial Committees of the various component societies shall have exclusive original jurisdiction over all complaints against a member of any component society or between members of the same or different component societies. In the event that any controversy arises between members of different component county societies the matter shall be referred to a joint committee comprised of the members of the County Judicial Committees of the counties involved. A chairman of such joint committee shall be selected at the time appointed for hearing.

(2) Upon receipt of such a complaint, allegation or grievance the County Judicial Committee shall make such investigation as may be required to determine all the relevant facts and circumstances and such investigation shall be conducted in a strictly confidential manner and in accordance with rules of procedure to be established by the Judicial Council. The physician concerned will have the right to appear in his own behalf.

(3) If after careful investigation the County Judicial Committee finds no cause for recommending disciplinary action against the physician or physicians involved, the case shall be closed and a report of such disposition shall be made to both parties and through the chairman to the Judicial Council of The Medical Society of New Jersey.

(4) If the County Judicial Committee finds that a complaint, allegation or grievance can be settled by conference or conciliation between or among parties, or if the County Judicial Committee determines that the interests of the parties involved will be best served by

the rendering of private advice to the physician in question, then the case shall be considered closed and a report of such disposition shall be made to both parties and to the Judicial Council.

(5) If the County Judicial Committee or the Joint County Judicial Committees shall find after hearing that a complaint, allegation or grievance involves a matter which in its opinion would empower the State Board of Medical Examiners to revoke the or suspend the license of a physician it shall be the duty of such committee forthwith by written complaint to refer the findings to the Judicial Council which shall in turn refer the complaint to the State Board of Medical Examiners.

Section 6—Special Procedure for Complaints Involving Fees for Professional Services

(1) In a complaint involving the just or proper amount of a fee for professional services the County Judicial Committees shall first investigate and attempt to effect an amicable settlement. If it shall be unable to reconcile the differences between the parties then it may determine the fee which it considers just and proper under all the circumstances of the particular case, stating in writing the basis on which the fee has been determined.

(2) If the society member against whom the complaint is brought shall agree to abide by the decision of the County Judicial Committee and shall register this agreement with the complainant in a form to be prescribed for this purpose then the case shall be considered closed and a report shall be rendered by the chairman to the Judicial Council.

(3) If, however, the member shall agree to the amount of the fee so fixed but fail to abide by his agreement then the County Judicial Committee may cite such member for contempt and take appropriate action thereon.

(4) If a member fails to accept the determination of the committee as to a just and proper fee the committee shall then proceed in accordance with the recommended uniform By-Laws hereinabove referred to in Section 5.

Section 7—Appeals

(1) Any member of the component county society aggrieved by an action of the County Judicial Committee, or any applicant for membership who has been excluded from membership by a county society, or any lay person aggrieved by an action of the county society Judicial Committee may appeal from the decision or action of the county society or the County Judicial Committee to the Judicial Council.

(2) Decision of the said Judicial Council in any matter so appealed shall be final except that further appeal may be taken by either party to the Judicial Council of the American Medical Association if the subject of the dispute falls within the jurisdiction of that Council.

(3) Any appeal to the Judicial Council of The Medical Society of New Jersey must be filed with the Judicial Council within forty-five (45) days of the date of the formal notice to the aggrieved party of the action of the component county society or of the county society Judicial Committee.

(4) Form of notice of appeal and procedure in hearing and adjudication of same shall be in accordance with the rules of procedure to be established by the Judicial Council, which shall be made available to the parties involved.

(5) Upon filing a notice of appeal the appellant and the component society or county society Judicial Committee will be required to submit to the Judicial Council all records and papers relative to the matter under appeal, all such papers shall be treated confidentially by the Judicial Council.

(6) The Judicial Council may affirm, modify or reverse by a majority vote of its members present and voting, the appealed decision.

(7) The Judicial Council may summon witnesses, take new evidence, and investigate the appealed matter in any manner in their opinion required to develop the information necessary for a proper decision.

(Amendment)

(8) In the event of an appeal by an aggrieved person against the decision of the County Judicial Committee to the Judicial Council of The Medical Society of New Jersey the Judicial council shall so notify the chairman of the County Judicial Committee at least thirty days before the date set for the hearing. All pertinent data in detail in regard to the appeal shall be submitted to the County Judicial Committee. The County Judicial Committee shall have the privilege of committee representation at the hearing in regard to the consideration of the appeal. The County Judicial Committee shall notify the Judicial Council as to the intent in regard to the hearing at least fifteen days before the hearing. Failure of notification shall waive the right of the County Judicial Committee to testify at the hearing.

(Amendment)

(9) Upon the completion of consideration of an appeal by an aggrieved person against the decision of the County Judicial Commit-

tee the Judicial Council must immediately submit its decision to the County Judicial Committee. If the decision of the Judicial Council is adverse to the decision of the County Judicial Committee the Judicial Council must submit a detailed report of the hearing and reasons for reversal of the decision to the chairman of the County Judicial Committee.

Section 8—Administrative and Procedure

(1) The administrative and legal costs of the operation of the Judicial Council shall be underwritten by The Medical Society of New Jersey in accordance with an annual appropriation for these purposes, to be approved by the House of Delegates.

(2) Every matter coming before the Judicial Committee shall be considered in a strictly confidential manner. Its record shall be subject to inspection exclusively by members of the Council and by legal counsel for the Society. Except for the purposes of consultation or testimony no member or officer of the Society save legal counsel, the executive officer of The Medical Society of New Jersey, and a stenographer, when his presence is deemed advisable by the members of the council, shall be present at a meeting of the Council when any appeal or other matter is under consideration.

(3) In pursuance of their investigatory and Judicial functions the county Judicial Committees as well as the Judicial Council shall have authority to summon members of the society to appear and testify either in connection with the complaint involving the member summoned or as witnesses in cases involving other members. Should any member fail to respond to such a summons the County Judicial Committee or the Judicial Council of The Medical Society of New Jersey shall be and hereby is authorized to cite such a member to his component society for contempt. Such a citation shall be considered equivalent to a charge of unethical conduct but shall be dealt with by the County Judicial Committee in accordance with the provisions uniform procedures of said committee herein referred to.

(4) The Judicial Council shall make public and from time to time in its discretion, revise and amend rules and regulations relating to procedures before County Judicial Committees and on appeal.

Such rules and regulations shall specify periods of notice, procedure for disposition of complaints against physicians who are not members of the society, procedure for notification of complainants and defendants, the nature of the charges advanced, maintenance of proper records, and such other rules of procedure as may be deemed necessary and proper.

CHAPTER VIII—COMMITTEES

FROM THE UNION COUNTY MEDICAL SOCIETY

Delete Section 14, Chapter VIII, and replace Section 14, Chapter VIII with this amendment:

Section 14—Reference Committees

A. Prior to or immediately after the organization of the House of Delegates at each annual meeting the President shall appoint, from the members of the House, reference committees of five members each, unless otherwise provided, to serve during the session at which they are appointed. To these committees may be referred any reports, resolutions, measure or propositions which have been presented to the House. When a matter is referred to any such committee, it shall meet forthwith, discuss the question referred, and hear debate thereon by any interested member of the society.

B. 1. The Reference Committee may recommend approval or disapproval of the matter which has been referred to it by a majority vote.

2. A member of a reference committee, who wishes to make a minority report must refrain from signing the majority committee report and must make his intention known to the other members of the reference committee while it is in executive session and prior to the presentation of the majority report to the House of Delegates.

C. The Reference Committee may not recommend changes, additions, or rephrasing that would alter the original subject or intent of the matter which has been referred to it.

D. The Reference Committee may recommend changes, additions or rephrasing of the matter which has been referred to it that would clairfy and accomplish the obvious intent of the referred matter.

E. The report of the Reference Committee shall be submitted to the House of Delegates for action at the third meeting of the House of Delegates. Any changes, additions or rephrasing recommended by the Refer-

ence Committee must be submitted to the House of Delegates as amendments to the referred matter and for approval must receive a majority affirmative vote by the members present at the meeting of the House of Delegates, except in the instance of amendments to the Constitution and By-Laws, when a two-thirds affirmative vote shall be required for approval.

F. Amendments to the report of the Reference Committee or to the report of proposed amendments to the Constitution or By-Laws may be introduced by any delegate from the floor at the time of consideration of the report of the Reference Committee except that amendments to the report proposed by the Reference Committee shall take precedence and be voted on first. To become effective, the amendment must be approved by a majority affirmative vote of the delegates present at the meeting except in instances of amendments proposed to amendments to the Constitution and By-Laws when a two-third affirmative vote is required.

G. Reference Committee shall convene not later than Seven P.M. on the date of the first meeting of the House of Delegates for consideration and debate of matters referred to the Committee. If a continuation of the meeting is necessary, the Committee shall convene not later than Nine A.M. of the date of the second meeting of the House of Delegates. All debates shall terminate by 11:30 A.M. of the date of the second meeting of the House of Delegates. The Committee shall immediately prepare a report for printing. The report of the Reference Committee shall be available at the registration desk to the delegates not later than Eight P.M. of the date of the second meeting of the House of Delegates.

CHAPTER XV—AMENDMENTS

FROM THE UNION COUNTY MEDICAL SOCIETY

Delete Chapter XV of the By-Laws.

Nominations for Emeritus Membership

(Reference Committee on Resolutions and Memorials)

The following nominations for election to emeritus membership at the 1956 Annual Meeting have been received from the county medical societies:

Atlantic County—Benjamin L. Gordon, M.D., Atlantic City; age 81; retired by reason of age and health; member in good standing over 20 years.

Bergen County—J. Bennett Edwards, M.D., Leonia; age 70; retired by reason of age; member in good standing since 1910.

George W. Finke, M.D., Hackensack; age 73; retired by reason of age; member in good standing since 1932.

Abraham B. Spiegelglass, M.D., Hackensack; age 70; retired by reason of age; member in good standing since 1915.

Joseph S. Van Dyke, M.D., Palisades Park; age 81; retired by reason of age; member in good standing since 1903.

Camden County—Earl S. Hallinger, M.D., Haddonfield, age 76; retired by reason of age and health; member in good standing since 1936.

Max Ruttenberg, M.D., Margate (formerly Camden); age 64; retired by reason of ill health; member in good standing since 1931.

Joseph D. Seiberling, M.D., Haddonfield; age 80; retired by reason of age; member in good standing since 1911.

Essex County—Anne Jane S. Brim, M.D., East Orange; age 73; retired by reason of age; member in good standing over 30 years.

Donald M. Caldwell, M.D., East Orange; age 51; retired by reason of disability; member in good standing over 20 years.

Hudson County—Roland J. Lynch, M.D., East Orange; age 70; retired by reason of age; member in good standing since 1927.

Mercer County—Nathaniel H. Koplin, M.D., Trenton; age 70; retired by reason of age; member in good standing since 1913.

George N. J. Sommer, Sr., M.D., Trenton; age 81; retired by reason of age; member in good standing since 1896.

Passaic County—Samuel Ginsburg, M.D., DeBary, Fla. (formerly Passaic); age 72; retired by reason of age and health; member in good standing over 20 years.

Louis Lipton, M.D., Passaic; age 66; retired by reason of disability sustained while in service; member in good standing since 1929.

Harold G. Walker, M.D., Wyckoff; age 67; retired by reason of ill health; member in good standing since 1914.

Somerset County—Edgar T. Flint, M.D., Raritan; age 78; retired by reason of age; member in good standing since 1926.

Mason W. H. Pitman, M.D., Bordentown (formerly Belle Mead); age 75; retired by reason of age; member in good standing over 20 years.

Medical Service Administration of New Jersey

(Reference Committee "C")

THE BOARD OF GOVERNORS

During 1955, Medical Service Administration of New Jersey has been active in the operation of the City of Newark Medical Plan. This provides for services rendered by physicians of the patients' choice on a fee-for-service basis for care of eligible persons confined to their homes by illnesses. It is designed to meet the needs of the indigent and medically indigent of the City of Newark on a reimbursement, rather than on an insurance basis.

The Plan is a successful demonstration of the cooperation of an official health agency with a voluntary agency controlled by the medical profession in helping to solve the problem of public medical care of the indigent and medically indigent. The table below charts the experience of the City of Newark Medical Plan over a seven year period, from 1949 to 1955. Statistics from 1944 to 1948 were listed in previous reports. It shows actual costs and portrays the changing economy.

In interpreting this table, may we remind you that the indigent are those whose names appear on the welfare rolls of the City of Newark. Medically indigent are those who, in the opinion of the Social Service Bureau of the City Board of Health, while having a sufficient income to meet the routine cost of a satisfactory standard of living, do not have sufficient income to pay for adequate medical care. Since the only fixed, or well-defined group are the indigent, the cost per capita in this report is limited to the indigent group. It is impossible to estimate the size of the medically indigent population. Medical indigency is a variable condition depending on the character and severity of the illness and the financial resources of the family.

As presented, the figures pertaining to the medically indigent load consist only of those medically indigent persons classified as medically indigent when requesting medical services, hence their costs are depicted on a cost *per case* basis only, rather than on a per capita basis.

Medical Service Administration has handled reimbursement for care of the indigent in Newark since 1943 and for care of the medically indigent since 1944. Before this plan went into effect, home care was provided by salaried city physicians. The present system is much more efficient and economical and has operated to the satisfaction of patients, physicians and city officials. The standard of medical care is higher and the costs to the municipality are less than under other systems. The greatest financial saving is due to the fact that under such a plan, many people are cared for at home and a fewer number are hospitalized.

Although organized for state-wide service, Medical Service Administration is currently being used only in Newark, and only for general assistance payments.

However, the Essex County Welfare Board has requested Medical Service Administration to set up a plan whereby the Administration would review claims and transmit payment of fees directly to suppliers of medical and other professional services rendered Welfare Board clients by licensed practitioners of the healing arts including physicians, dentists, doctors of surgical chiropody, optometrists, ophthalmic

dispensers and technicians and others; also for nursing, x-ray and laboratory services; hospital out-patient or clinic services, and appliances and sick room supplies.

A tentative draft of a proposed agreement between Medical Service Administration and Essex County Welfare Board has been prepared as a basis for negotiation; there have been several meetings of representatives of both agencies; a five-member medical advisory committee has been appointed by the president of the Essex County Medical Society to assist in formulating an acceptable agreement and to serve as a board of arbitration when such agreement becomes operable. Exploratory meetings of this committee with officials of the Essex County Welfare Board were held in November 1955 and March 1956.

An amendment to our Articles of Incorporation, broadening the scope of eligible services, has been approved by the Department of Institutions and Agencies. This qualifies the Administration to participate in such a plan as requested by the Essex County Welfare Board, and to set up a program to provide medical and surgical coverage for dependents of servicemen, as proposed in HR 7994; also to cooperate with and participate in any plan recommended by a Commission which may be created on the enactment of Assembly Bill AJR 1 to integrate public medical and surgical services to the indigent and medically indigent of New Jersey, and to carry out and perform any and all purposes approved by The Medical Society of New Jersey for making such services available.

Medical Service Administration of New Jersey has demonstrated to The Medical Society of New Jersey its value in serving as a medium through which medical care may, by plans or arrangements with governmental authorities at Federal, State or other level, be made available to individuals and groups not eligible for obtaining insurance protection or service benefits against illness, on a non-profit voluntary basis which preserves the patient-physician relationship and allows free choice of physician and patient.

The Board of Governors wishes to express to The Medical Society of New Jersey their appreciation of and gratitude for the continued moral and financial support given to Medical Service Administration over the fifteen years of its existence.

INDIGENT (RELIEF) PERSONS

Year	1949	1950	1951	1952	1953	1954	1955
Mean number of persons on welfare rolls during year	7986	7804	4977	3794	3500	5273	5281
Number of cases* during year	——	——	——	——	1481	1640	1964
Value of approved services	$12,046	$13,092	$9,105	$6,726	$5,003	$5,731	$6,565
Cost per capita of relief load per year	1.51	1.50	1.83	1.77	1.48	1.08	1.24
per month	0.126	0.125	0.152	0.147	0.123	0.09	0.13
Cost per case per year	——	——	——	——	3.378	3.494	3.343
per month	——	——	——	——	0.281	0.291	0.278

MEDICALLY INDIGENT CASES*

Number of cases during year	4155	4446	3450	3409	2648	3315	3335
Value of approved services	$15,119	$15,298	$13,705	$11,366	$8,579	$10,764	$11,151
Cost per case per year	3.639	3.441	3.972	3.334	3.24	3.247	3.343
per month	0.303	0.287	0.331	0.278	0.27	0.27	0.278

*The word "case" means family as distinguisned from "person" referred to under report on number of indigent on relief rolls.

Medical-Surgical Plan of New Jersey

(Reference Committee "C")

THE BOARD OF TRUSTEES

The year ending March 1, 1956, has been a year of renewed growth for Medical-Surgical Plan and a year of planning for the expanded services to be provided under the Series 1956 Contract. Enrollment under the Plan is presently approaching 1,500,000 persons, representing approximately three-fourths of the enrollment of the New Jersey Blue Cross Plan.

During the calendar year, 1955, the Plan's operations resulted in a modest addition to reserve amounting to 3.2 per cent of earned subscriptions, as against 0.6 per cent in the calendar year 1954. This addition to reserve is largely traceable to the Plan's increasing enrollment, the effects of which in terms of a growing claim load are not fully realized until a later date.

On May 1, 1956, the Plan will begin conversion to the Series 1956 Contract. It is highly encouraging that a large proportion of enrolled groups have already signified their intent to take advantage of the opportunity to convert their entire group to the new Subscription Contract as of the issuing date of May 1, 1956, rather than to await the later anniversary dates of the respective groups. This may indicate that Subscribers to the Plan, generally speaking, are willing to pay higher premiums for broader benefits under the New Jersey Blue Shield Plan.

Appendix A (following) is a summary of the history of the Plan insofar as the major indices of its growth of service, earnings and enrollment are concerned. The New Jersey Blue Shield Plan is now receiving earned subscriptions at the rate of $18,000,000 a year under the current Series 1949 Contract—the rates of which have been unchanged since 1949. The Plan is currently paying more than 86 cents of every dollar of earned subscription for eligible professional services rendered to Subscribers. The Plan's operating expense has been reduced from 11.2 per cent of earned subscriptions in 1954 to 10.1 per cent in 1955.

PARTICIPATING PHYSICIANS

As of March 1, 1956, a total of 5271 physicians were maintaining Participating Agreements with Medical-Surgical Plan of New Jersey. This represents 79.4 per cent of all physicians of record in New Jersey. A table of participation of physicians by Counties as of December 31, 1955, is appended as Appendix B.

An analysis of participation among various specialties reveals the greatest degree of participation among pediatricians (89.5 per cent), internists (85.9 per cent) and general practitioners (81.5 per cent). As of March 1, 1956, 78 per cent of general surgeons were Participating Physicians in the Plan; 74.6 per cent of orthopedic surgeons; 61.8 per cent of spe-

APPENDIX A

MEDICAL SURGICAL PLAN OF NEW JERSEY
SUMMARY OF OPERATIONS

Year Ended December 31	Earned Subscription Income	Claims Incurred Amount	Claims Incurred % of Income	Operating Cost % of Income	Persons Enrolled End of Period
1942	11,148	5,395	48.4	51.1	4,131
1943	74,498	49,562	66.5	23.9	16,015
1944	187,708	135,605	72.2	18.9	30,427
1945	326,530	208,288	63.7	17.5	49,441
1946	540,227	370,576	68.6	16.8	88,088
1947	947,945	681,922	72.0	17.1	143,700
1948	1,524,814	1,203,651	79.0	15.0	236,604
1949	2,545,518	1,979,542	77.8	13.8	353,827
1950	5,252,060	4,278,098	81.5	12.9	499,882
1951	8,031,305	6,527,374	81.3	10.9	669,906
1952	10,952,158	8,720,257	79.6	10.8	997,303
1953	14,916,204	12,715,442	85.2	9.6	1,183,336
1954	15,864,137	13,991,592	88.2	11.2	1,196,804
1955	17,796,979	15,635,398	86.7	10.1	1,389,965

cialist obstetricians and 56.9 per cent of anesthesiologists. Apart from the impressive degree of formal participation on the part of the physicians of New Jersey, the Plan has been especially encouraged by their cooperative spirit and their increasing understanding of the Plan.

MAJOR CHANGES UNDER NEW SUBSCRIPTION CONTRACT

The Series 1956 Contract will contain a number of important benefit changes of particular interest to members of the Society as compared to the current Contract Series 1949 as follows:

1. *Medical Benefits*:

   Eligible medical (non-surgical) care in hospital will be increased from a limit of 21 days in a Contract Year to 21 days for hospital admission, provided that any subsequent hospital admission occurring within 90 days of previous discharge shall be considered continuous hospitalization.

2. *Surgical Services in O.P.D.*:

   Surgical services rendered in the Hospital Out-Patient Department, without admission of the patient as a bed patient, need no longer be "of an emergency nature" to be eligible for Plan benefit. Instead, surgery of a cutting or cauterizing nature performed in O.P.D. will be eligible to the same extent as such surgery for a bed patient in hospital under present Contract.

3. *Surgical Services outside of Hospital*:

   At present, there is a maximum eligible payment of $25 for emergency surgical services rendered outside of hospital within 48 hours after an accident. Under the new Contract, Plan payment will be made in accordance with the surgical schedule to a maximum of $50, for emergency surgical services which commence within 48 hours after an accident.

4. *Newborn Infant*:

   The newborn baby will be an eligible person from the date of birth, instead of the seventh day of life.

5. *Consultations*:

   Plan payment for eligible consultations will be limited to one formal, non-mandatory consultation during any one hospital admission. A Participating Physician who must travel more than 10 miles to render such consultation will not be required to accept Plan payment as full payment for his consultation

APPENDIX B
REPORT ON PARTICIPATING PHYSICIANS — MEDICAL-SURGICAL PLAN OF N. J.

County	Total Eligible Physicians	P.P.	% P. P.
Atlantic	202	172	85.1
Bergen	709	498	70.2
Burlington	118	98	83.1
Camden	379	314	82.8
Cape May	55	47	85.5
Cumberland	97	85	87.6
Essex	1568	1283	81.8
Gloucester	93	72	77.4
Hudson	709	560	79.0
Hunterdon	51	45	88.2
Mercer	371	313	84.4
Middlesex	290	230	79.3
Monmouth	308	240	77.9
Morris	230	185	80.4
Ocean	68	53	77.9
Passaic	536	419	78.2
Salem	51	42	82.4
Somerset	104	81	77.9
Sussex	39	30	76.9
Union	601	419	69.7
Warren	42	36	85.7
Total in New Jersey	6621	5222	79.4

As of December 31, 1955, there were 166 physicians located outside New Jersey who are maintaining Participating Physician Agreements with Medical-Surgical Plan. To be a Participating Physician an eligible physician is required to hold a license for the practice of medicine and surgery in the State of New Jersey. Hence the grand total of all physicians listed with the Plan as Participating Physicians, as of December 31, 1955, was 5388.

services, regardless of the patient's income status.

6. *Change in Income Limit for Family Contracts*:
The present Contract carries a flat income limit of $5,000 for service benefits, irrespective of the number of people covered by a Contract. Also this limit applies to the income of the *subscriber only*, regardless of the income of the subscriber's spouse, if any. The new Series 1956 Contract will continue to apply the income limit of $5,000 to *single* person Contracts, but the income limit for all multi-person Contracts will be $7,500, applied to the *combined incomes* of the subscriber and spouse, if any, said respective incomes to be calculated for the period of 12 calendar months immediately preceding the month in which the services commenced for which Plan payment is made.

7. *Direct Payment to Subscriber for Services by Non-Participating Physician*:
Under the terms of the Series 1956 Subscription Contract, the Plan may make payment to the Subscriber when the patient is attended by a physician who is eligible to be, but is not, a Participating Physician. The Plan wishes to emphasize that this revision—twice approved by the House of Delegates—is intended as a recognition to the Participating Physician without whose participation the Plan could not exist. It is definitely *not* a punitive measure designed to coerce non-Participating Physicians.

8. *Schedule Changes*:
Apart from the specific Contract provisions listed above, the Schedule of Payments applicable to the Series 1956 Contract includes provisions for
   (a) Selective increases in payments for various surgical procedures, including many items in which reductions had been made in 1952.
   (b) An increase from $25 to $35 in the special additional allowance for medical services in a hospitalized case requiring prolonged or repeated hospital visits within a 48 hour period. This allowance would also be available in such cases where the patient expires within his eligible period of hospitalized medical care.
   (c) A general increase in payment for eligible anesthesia services.

PROSPECTS FOR FUTURE EVOLUTION

For the first time, the Series 1956 Subscription Contract contains a provision which enables the Plan to revise its Contract Rate—subject, of course, to the approval of the State Department of Banking and Insurance—without going through the process of issuing an entirely new Contract. This provides the Plan with a greater flexibility in its future development.

Your Blue Shield Plan is a dynamic and rapidly evolving program. In its constant effort to meet the requirements and challenges of modern medical practice, the Plan maintains liaison with representative groups of the profession. Many conferences have been held, and will continue to be held in the future, with representatives of all the general and specialized groups within the profession, not only on necessary changes in the Schedule of Payments but on possible alterations in the scope of benefits.

In this respect, the Plan is seeking to fulfill the directive of the House of Delegates of The Medical Society of New Jersey, as recorded in the proceedings of the 1955 session of that body, respecting future changes in the Plan's scope of eligible services.

In 1955, the House of Delegates adopted a report requesting the Plan to consider "inclusion of x-ray treatment for cancer as an eligible service for in-patients, ambulatory outpatients or non-hospital patient, if actuarially feasible."

In November, 1955, the Trustees of The Medical Society of New Jersey adopted a resolution requesting the Plan to proceed as rapidly as possible toward the development of a further new Contract or revision of Contract. The action of the Board of Trustees was as follows:

"Immediately upon the issuance of its new Series 1956 Subscription Contract, the Plan proceed to prepare a new Subscription Contract, to be issued as soon as feasible, implementing the action of the House of Delegates of The Medical Society of New Jersey concerning the inclusion of medical services in the fields of radiology, anesthesiolgy, laboratory medicine, pediatrics, etc., and that it study the problem of increasing the benefits to the participating physician." (i.e., the Trustees of the Plan interpret the last reference to apply to benefits for medical care vis-a-vis surgical care). In response to this directive, the Plan is presently engaged in necessary studies preparatory to fulfilling the request of the Medical Society.

APPORTIONMENT OF SURGICAL BENEFITS

In conformity to the directive of the House of Delegates in its last two annual sessions in regard to the apportionment of available surgical benefits, that the Plan establish a procedure for the allocation of a portion of the available surgical benefit in surgical cases, the

Board of Trustees of the Plan has adopted the following resolution:

"RESOLVED that effective with respect to eligible services rendered on and after May 1, 1956, and concurrence by the Department of Banking and Insurance, there be added to the General Provisions of the Schedule of Payments the following provision:

> When an eligible physician collaborates with the eligible operating surgeon in rendering, concurrently, any medical or surgical service to a surgical patient during the period of eligible service in an eligible hospital, and Plan payment for such service is not eligible under some other item in the Schedule of Payments, then such service shall be eligible for Plan payment from the total available benefit under the Schedule of Payments for the particular surgical procedure, and the same may be apportioned by the Plan between the surgeon and such collaborating physician upon certification by the surgeon and collaborating physician that such concurrent service has been rendered. The amount of the apportionment payable to the collaborating physician may vary from $10 to $50 depending upon the surgical procedure and the available maximum benefit thereof, and the determination of the Plan with respect to such apportionment shall be conclusive. Such apportionment of available benefits shall be made under the following circumstances, as approved by the American Medical Association.
>
> (1) That on certification of the operating surgeon, the scheduled amounts available for services rendered may be paid by the Plan to a physician other than the operating surgeon provided that such other physician has properly rendered such services;
>
> (2) That each physician submit his individual report and charges to the Plan according to the services rendered the patient;
>
> (3) That the Plan make separate payment for the services of each physician; and
>
> (4) That the Plan notify the patient of each payment made by the Plan."

A proposed procedure has been submitted to the Department of Banking and Insurance, and, if approved by the Department, the attending surgeon in reporting his claim for services in a surgical case, may at the same time report any concurrent service rendered in that case by another physician, and may authorize the Plan to apportion a part of the total maximum eligible payment for the surgical procedure to the physician named by the attending surgeon. This procedure will require the physician rendering the concurrent service to submit a report of the same. Such apportionment of available surgical benefits will be made only under the Series 1956 Subscription Contract.

PROFESSIONAL RELATIONS PROGRAM

During the past year, the Plan has improved and expanded its program of professional relations. This is designed to keep all physicians fully informed of Plan procedures and changes of Plan policy or procedure which affect the physician in his day to day dealings with the Plan. Beyond that, there is the underlying need to inform physicians of the basic philosophy of Blue Shield and the vital role the doctor plays as a Participating Physician.

Blue Shield was created by the medical profession to help the profession meet its responsibility to provide the people with a degree of economic security against the consequences of illness and disability.

It is essential that the Plan reflect at all times the ideals and purposes of the medical profession. The Professional Relations Program of Blue Shield is a two way street. It not only enables the Plan to keep the profession informed, but it also assures that the Plan will be responsive to the needs and wishes of the profession.

This Professional Relations Program takes various forms. One aspect is exemplified in this report to the House of Delegates of The Medical Society of New Jersey. The Plan's supplemental report to the House of Delegates covering matters arising between now and the time of the Delegates Meeting, is another example. A further example of Professional Relations activity is the Plan's Exhibit at the Annual Meeting of the State Society.

Perhaps the most important aspect of our Professional Relations Program is our field service. Miss Marie Smithuysen, who has been engaged in this service for more than a year, has recently been joined by Mr. James Zotti as the second full time special field representative of Medical-Surgical Plan. Under the direction of Doctor Nicholas F. Alfano, Associate Medical Director, these workers conduct informative sessions for physicians at community hospitals; they call upon physicians to answer their questions and provide information concerning Plan procedures; they present Plan information before hospital medical staff groups and meetings of doctors' secretaries, and generally they assist physicians in their day to day relations with Medical-Surgical Plan patients.

As rapidly as possible, this service is being extended to cover the entire State. To date, more than 2,000 physicians have been interviewed in the course of our hospital information sessions which represent only one aspect of the program. Hospital staff groups or local

medical societies which desire to have a representative of the Plan present information and respond to questions concerning Plan policies and procedures are invited to make arrangements through Doctor Alfano at the Plan office.

In its continuing effort to "feel the pulse" of the profession regarding Plan procedures and policies, Plan representatives are maintaining a continuous liaison with representative groups. The Medical Director and his staff welcome all opportunities for conference with representatives of the profession, geographically or by specialty, to the end that understanding of the Plan may be enhanced throughout the profession.

The Board of Trustees of Medical-Surgical Plan takes this opportunity to express its appreciation to the Participating Physicians whose steadfast support and cooperation have made possible the continued service and development of the Plan.

The Board also wishes to express its appreciation to Hospital Service Plan of New Jersey for its continued service and cooperation. Finally, a word of gratitude is extended to the staff of Medical-Surgical Plan for loyal and devoted services rendered.

County Societies • • •

Atlantic

PETER H. MARVEL, M.D., President, Northfield

For the first time in its history the Medical Society of Atlantic County inaugurated its new officers at an Installation Dinner. This affair coincided with the American Medical Association Convention in Atlantic City in June. We were honored to have present at our head table most of the officers and trustees of the American Medical Association, including last year's president, Dr. Walter B. Martin and the current president, Dr. Elmer Hess. To add further distinction, the immediate past president of The Medical Society of New Jersey, Dr. Elton Lance and our current president, Dr. Vincent P. Butler, who did a magnificent job as the installing officer, were also present. The membership of Atlantic County was happy to rub shoulders and play host to our state and national dignitaries. We were glad to have the opportunity to know them better and appreciate their genuine sincerity.

Capitalizing on last year's location we again held our monthly meetings in the spacious, comfortable Children's Seashore Home which is centrally located and provides ample and easy parking. The Woman's Auxiliary also held their meetings at the same time and place permitting common transportation and an opportunity to conclude our meetings with a social get-together and monthly buffet. Combining business, professional education, and social opportunity seems to appeal to most of our membership and has helped swell our monthly attendance to an all time high.

Our season opened with a gala Barbecue Dance jointly with the Woman's Auxiliary on September 24 at the Linwood Country Club. This delightful affair initiated the close cooperation between our two organizations. Friendly inter-personal relationship among ourselves is a vital part of a good active medical organization. The informality and relaxed atmosphere of such an affair permits us all to know each other better as fellow men and not just as colleagues in the profession.

Our programs for the year were stimulating and representative; we are fortunate to have had such outstanding talent. The meeting schedule was as follows:

October—Dr. Francis Carter, Professor of Gynecology at Duke University and Dr. Bernard P. Widmann, Professor of Radiology at the University of Penna.: "Cancer of the Cervix."

December—Dr. Lucien A. Gregg, Professor of Medicine, University of Pittsburgh: "Abdominal Pain of Obscure Origin."

January—Dr. Abraham Rakoff, Clinical Professor of Endocrinology, Jefferson Medical College: "Advances in Endocrine Therapy."

February—Dr. William L. Watson, Director of Cancer Research, Bellevue Medical Center: "Newer Concepts of Cancer."

March—New England Medical Clinics (film): "Acute Abdominal Conditions."

April—Dr. Harold J. Jeghers, Director of the Department of Medicine, Georgetown University: "Oral Manifestations of Systemic Disease,"

May—Annual Business Meeting and Election of Officers.

The highlight in Atlantic County this year was the celebration of our seventy-fifth birthday as a society. This was commemorated by a "Diamond Jubilee" formal dinner dance held at Haddon Hall in Atlantic City, November 19, 1955. Represented at this auspicious occasion were officers from the pharmaceutical, dental, nursing and legal professions; and from the press and journal societies of Atlantic County. Also present were our state senators and assemblymen, mayors and freeholders. We were honored by the presence of our state President and his wife, Dr. and Mrs. Vincent P. Butler. Dr. Elmer Hess, President of the American Medical Association, delivered a stirring address following his worthy introduction by our own David Allman, a Trustee of the American Medical Association. This once-in-a-lifetime celebration provided fun and fellowship. It reviewed progress and reflected sentiment. It was a great stimulus to public relations, and we received the felicitations of many business and social organizations throughout the county. The press was generous and the prestige of our society and doctors as a whole were eulogized upon this memorable occasion.

During this year our membership increased by twelve regular and four associate members. We mourn the loss of Dr. Edward F. Uzzell, a county past president and member for thirty-six years. Our Annual *Bulletin* award, a citation of merit from the society to some non-member who has furthered the interests of our society, was presented by the editor, Dr. Samuel Diskan to the Honorable Elmer Brown of Atlantic City for his legal counsel rendered without remuneration, on several vital society problems during the past year. The society endorsed the courageous leadership of Dr. Vincent P. Butler on the subject of poliomyelitis immunization in this county.

The wholehearted support and cooperation of my fellow members, committee chairmen, and officers, whose fine efforts made possible our accomplishments in Atlantic County, have made my year as president one of gratitude and pleasure.

Bergen

JOHN E. MCWHORTER, M.D., President, Englewood

The 1955-56 year in Bergen County may be very briefly described as one of growth and change. As our population continues to increase enormously, more and more doctors are moving to the suburbs from New York City, or (especially the younger man) are deciding that a new growing suburb is the locale for an active, ambitious doctor to start his practice and raise his family. We have had to move into larger quarters, to retain additional office staff and a new Executive Secretary and through it all are continuing our efforts to acquire our own building as Society headquarters.

From January 1, 1955 to March 31, 1956, a period of 15 months, we have elected 29 new members to Associate Membership, 22 to Regular from Associate, 14 to Regular by Transfer, 2 to Regular from Courtesy and 9 new Courtesy members, a total of 76 new members. 2 returned from military service. During this period we lost 17 members as follows: 3 deceased, 4 resigned and 10 moved to other areas.

Our Executive Committee members have been faithful in attendance at committee meetings. Attendance at our general monthly meetings, however, leaves something to be desired and will be one of the projects for the coming year. Our speakers at these meetings were as follows:

In January, Dr. Edward Reifenstein spoke on steroid hormones. In March we heard a talk on chemotherapy in malignancy by Dr. Henry Diamond. The April program was featured by a talk on peripheral vascular diseases the surgical aspects being presented by Dr. Henry Haimovici and the medical aspects by Dr. Heinz Lippman. In May, we heard a distinguished British biochemist talk on radiation effects in living tissue.

In the fall we opened the season with a talk by Dr. Robert Hayward Kennedy who spoke on the early care of the injured. In November, Gerald Pratt spoke on surgery for arteriosclerosis. Dr. Nathan Kline, the chief of research at the State Hospital in Orangeburg, N. Y. talked to us in December on the use of chlorpromazine and reserpine in general medicine. In January, we heard Dr. Charles Ragan speak on arthritis. The last meeting, before the preparation of this report, was in February when Mr. Robert Bell, Counsel for the New York Medical Society led a discussion on the legal aspects of medical practice.

These speakers have been secured through the conscientious effort of Richard P. Keating, M.D., Chairman of our Scientific Program Committee.

Our Graduate Education Committee under the chairmanship of Dr. Anthony Susinno conducted two courses. One was on elementary electrocardiography. The instructor was Dr. Charles Enselberg, Chief of Cardiology, Polyclinic Hospital, New York City. Dr. Enselberg was the instructor for the second course on the modern treatment of heart disease. Both courses were well attended and registration completely filled.

Working in close cooperation with two daily newspapers the Society sponsored 6 forums and invited the public to attend and participate without charge. These were:

"Your Healthy Child"—February 16, 1955—Attendance 400

"Living with Old Age"—March 2, 1955 — Attendance 500

"You and Your Heart" — October 19, 1955 — Attendance 400

"You and Your Allergy"—October 26, 1955—Attendance 900

"Your Child's Behaviour"—February 21, 1956—Attendance 750

"Birth of a Baby"—March 6, 1956—Attendance 650

The steady growth in attendance reflecting increasing public interest is a source of great saisfaction from a public relations point of view. Each panel consisted of a moderator and four speakers. All five were our members. The public was invited to participate by mailing questions in advance on a coupon published by each newspaper for one week prior to each forum. In every instance, more questions were received than could be answered in the two hour time allowed.

In March 1955, a resolution giving provisional approval of the Salk Vaccine Program pending the results of the 1954 studies on its safety and effectiveness was passed and forwarded to the State Department of Health. In November 1955 another resolution based on Dr. Bergsma's October release of Regulation 1 was passed, cleared on the telephone with The Medical Society of New Jersey, published in the newspapers and forwarded to the State Department of Health. This resolution stated:

"The Bergen County Medical Society will cooperate with state and municipal agencies, in the administration of the present program of Salk vaccine distribution as set up by and in each municipality insofar as the administration of vaccine to children under 15 and pregnant women is concerned. This cooperation excludes the formulation of policy and the responsibility for the successful conclusion of the program."

The purpose of this resolution was to inform the public, the State Department of Health and The Medical Society of New Jersey that this Society would accept no responsibility for setting up the free public clinics advocated by the Department of Health nor for the successful conclusion of the program; but because the program had already been announced (and in spite of the fact that this Society had not been consulted) it nevertheless agreed to cooperate in the administration of the vaccine when and if called upon. The authorization of free public clinics with no "means test," the timing of the releases to the press while there still existed an extreme scarcity of the vaccine, are actions which caused great dissatisfaction among our members. However, many of them have proceeded to work closely with the clinics that have been set up in our municipalities.

On February 22, 1955 the official opening of the Bergen Community Blood Bank took place. This badly needed community effort was sponsored from its inception by this Society, several members of which sit on its Executive Board. Its first year has been characterized by the surmounting of problems, one after another. It is a great source of gratification to be able to report that the Blood Bank is well on its way to achieving its goal of becoming the principal source of the supply of blood to the 670 thousand residents of the county, in cooperation with its half dozen hospitals.

For more than a year, efforts have been made to solve the problem of physicians' automobile parking in New York City. This is a very exasperating problem. Many of our members serve on medical staffs of New York City hospitals, give large amounts of time to their clinics, attend courses there and do various types of graduate work and even treat patients across the river. These efforts have been fruitless in spite of cooperation from the Medical Society of the County of New York.

Working in close cooperation with educational authorities and school nursing groups in the county, our committee, spearheaded by the conscientious efforts of Dr. R. W. ter Kuile, has published a set of recommended standards for school health examinations, which have been widely accepted throughout the county.

Finally, a note of thanks to the ladies of our Auxiliary. In April 1955 the Auxiliary turned over a sizable sum of money to the Society to be used as a fund provided annually, for a scholarship for a medical student. Their annual nursing scholarships have been increased to twelve, divided among the three schools of nursing in the county. Throughout the year, these devoted ladies have been a dynamic source of assistance in many ways.

Major problems to be dealt with next year are: acquisition of a permanent headquarters building, integration of our new members in Society activities, more participation in those activities by our older members and the establishment of an aggressive planned, continuing public relations program.

Burlington

Morris A. Robbins, M.D., President, Columbus

This has been a year of reorganization for the Burlington County Medical Society, highlighted by the drafting of a new Constitution and By-Laws containing a more realistic, up-to-date approach to the workings of a component medical society and attuned to our experiences in organized medicine. The Executive Committee has been empowered to handle routine affairs of the Society between stated meetings, and to expedite business so that more time can be given to scientific and social aspects of our monthly gatherings. This monumental work has been carried out under the chairmanship of our esteemed member and Fellow of The Medical Society of New Jersey, Dr. J. Howard Hornberger, to whom we express our gratitude.

Controversy this year was touched off by the decision of the Freeholders to close the Newcomb Hospital upon the retirement of another of our distinguished members and Fellows, Dr. Marcus W. Newcomb. The Society unanimously favors the retention and modernization of the tuberculosis facilities of our fast-growing county with the hope that the program can be enlarged to handle chronic disease as well.

The stormiest session in the modern history of our group centered around the mass immunization program for poliomyelitis. The position of those members who believe that free clinics to start the program, without a "means test," is one of the strongest weapons against the apparent general deterioration of the doctor-patient relationship and socialized medicine was so strongly presented and supported that the final vote was contrary to the advice of the State Society. Such difference with the general opinion of our State Society is unusual from our county.

Our proudest achievement for the year was the creation of an adquate *Journal* under the editorship of another well-known member, Dr. William E. Bray. This is modestly called the *News Letter*, but it is actually a sizable undertaking, for which we appreciate the efforts of the Journal Committee.

For the past four years we have sponsored a Scholarship Fund for student nurses and are glad to report that four girls are now being supported in good nursing schools by this program.

Our final kudo goes to Dr. R. Winfield "Civilian Defense" Betts, whose vital interest and endless work as our Society Secretary and State Medical Defense Chairman has warranted our hope that he may some day be rewarded by a good Department of Civilian Defense at all government levels.

The Society mourns the loss by death of Dr. Edward R. Hunter of Delanco and Dr. Harold E. Longsdorf of Mount Holly, both of whom were highly esteemed general practitioners for many years.

As a reflection of the gradual urbanization of our County, we have admitted six new members, thereby boosting our membership to eighty-seven.

In spite of the heavy load of business we have found time to enjoy the following scientific programs:

September: Dr. Edward H. McGehee, Philadelphia, "Problems of the Common Anemias."

October: Dr. George Ross Fisher, Philadelphia, "Management of Goitre."

November: S. Walter Foulkrod, Philadelphia, "Doctor Beware!"

December: Symposium on Emergency Treatment, Drs. Reagan, Darst, Wyman and Davis, all of our own membership.

February: "Metastatic Carcinoma of the Breast," Drs. Wolgamot, MacNeal, Kane, Bauer and Reagan, of our Society.

March: Joint meeting with the Burlington County Bar Association, Mr. John Duffy, Trenton, "Crime Goes Scientific."

We have continued our "home talent" scientific programs for several years and we recommend them to our fellow smaller societies as a source of knowledge and expression from colleagues of similar interest and status.

The President takes this opportunity to thank the members for their confidence and cooperation and to express his gratitude to the officers and committee members for their hard work.

Camden

ARTHUR G. PRATT, M.D., President, Camden

To stimulate attendance at the meetings, the Camden County Medical Society held its first meeting of the 1955-56 season at the Cherry Hill Inn where dinner was served to the members. The success of the move was attested by the fact that 142 attended out of a total membership of 325.

The Society is considering holding some of its monthly meetings at the three general hospitals. Our Society building is in the center of Camden City where little parking space is available. The Society also is considering selling its present quarters and erecting a new meeting place outside the City.

The Auxiliary is working with our Medical History Committee preparing a biography of all members since 1880. It will be published next year in commemoration of our 110th Anniversary.

Members are being polled on their willingness to accept local civic appointments such as school physician and their willingness to serve on committees to meet with governing bodies to urge appointment of fully qualified physicians to all positions dealing with medical matters. In recent years such offices were often filled by practitioners ineligible for membership in a county society because class A school graduate were not available or because we did not urge their appointment.

Cape May

WILLIAM A. DOEBELE, M.D., President, Ocean City

In January 1955, the Medical Society of Cape May County heard Dr. David B. Scanlan of Ventnor speak on abdominal aneurysm simulating renal colic. In March, Dr. Paul Pettit of Ocean City discussed arterial changes in the fundus in hypertension.

A special meeting was held in May to discuss the policy of the Society about fees for administration of Salk vaccine. At the regular May meeting, Dr. J. M. Naame of Atlantic City spoke on congenital hip deformities in children.

The September meeting in Ocean City featured two films on viruses which were shown by Mr. Anderson of the Lederle Company. Refreshments were served after the meeting giving the members a chance for discussion and pleasant social contacts.

At the November meeting Dr. Bernard J. Shuman of Atlantic City spoke on meningitis. A beginning was made in the revision of the Constitution.

At the January meeting in 1956 the following officers were elected:

President: Edward B. Tyson, M.D., Ocean City.
Vice-President: Carl J. Records, M.D., Cape May.
Treasurer: Harold F. Hughes, M.D., Cape May.
Secretary: Samuel J. Mazzotta, M.D., Wildwood Crest.

They will take over their duties at the May meeting.

On April 19, 1956, we held a joint dinner meeting with the Cape May County Bar Association. There was an exceptionally large turnout of members of both professions not only from this county but from the surrounding area. The Honorable David F. Maxwell, Nominee for President of the American Bar Association, and Dr. Burgess Gordon, President of the Woman's Medical College, Philadelphia, were the guest speakers. This was also the occasion for honoring Dr. George F. Dandois, who has practiced medicine for 60 years and was recently elected an Emeritus member.

Cumberland

Nicholas E. Marchione, M.D., President, Vineland

The Society this year is gratified to report the marked increase in growth of membership throughout Cumberland County. This totaled six active members and six associate members. They are a diversified group of general practitioners and specialists. We are both honored and saddened to note the advancement to Emeritus status of the following members: Hugh W. Baker, M.D., Vineland, F. A. Davies, M.D., Elmer, and A. G. Sheppard, M.D., Elmer.

We regret the passing of Dr. Fred Snyder of Bridgeton, Dr. Charles B. Neal, Millville, Dr. Muriel Ramsey, Riverside, Dr. Herbert H. Wilson, Bridgeton and Dr. Margaret Warlow, Bridgeton, an honorary member of the Cumberland County Medical Society.

Last year's administration closed April 1955 with an enjoyable and thoroughly enlightening tour of the Kimble Glass Company, Vineland, followed by the annual election of the following officers: President, Nicholas E. Marchione, M.D.; President-elect, Sherman Garrison, Jr., M.D.; Secretary, Mary Bacon, M.D.; Treasurer, Samuel B. Pole, III, M.D.; Reporter, Paul K. Ayars, M.D.

Interprofessional relations were improved this year by a joint dinner meeting with the local Pharmaceutical Association as hosts. This welcome innovation will be continued as an annual function. A joint social assembly with lawyers is also planned.

Our big annual "Spring Outing" meeting was held in June, through the courtesy of the Ionized Club of Bridgeton and the Owens Illinois Glass Company. We were especially pleased by the attendance of our own Dr. Albert B. Kump, First Vice-President of The Medical Society of New Jersey, Dr. Vincent P. Butler, President of The Medical Society of New Jersey and Mr. Richard Nevin, Executive Officer of The Medical Society of New Jersey.

Another Society innovation was the formation of a Nominating Committee to facilitate election procedures.

Public relations were improved by the excellent conduct and administration of the Diabetes Detection Drive which was an unqualified success and by the lively, interesting and educational forum conducted by the Cumberland County Heart Association whose activities we heartily endorsed. The Heart Association also conducted a professional forum for the physicians of South Jersey which contained a panel of illustrious physicians well versed in cardiology in all its branches. This will be repeated in April this year. Everyone is welcome.

The Woman's Auxiliary is now firmly established and has become an invaluable aid to our Society, helping in our professional and public relations, and ever ready for the chores that only they can do so well. Their program for the year was a splendid tribute to their zeal. We thank them for a most enjoyable Christmas Supper Dance. Our State Delegates attended meetings one hundred per cent. Also our Welfare Committee have attended their meetings one hundred per cent.

My sincere thanks go to Dr. Sherman Garrison, Jr., our Program Chairman, for his splendid job in providing meeting places and speakers who were as follows:

George I. Blumstein, M.D., Assistant Professor of Medicine, Temple University spoke on bronchial and cardiac asthma.

William T. Fitts, Jr., M.D., Associate Professor of Surgery, University of Pennsylvania, reviewed diagnosis of the diseases of the colon.

Michael Mendelsohn, M.D., Ancora State Hospi

tal, moderated a discussion of commitment procedures.

Mr. Belford L. Seabrook spoke about the history and growth of Seabrook Farms and its relationship to the frozen food industry.

My thanks to the members of my Executive Committee for their splendid cooperation, by their attendance and counsel throughout the year. Thanks to all the committees and their chairmen for the handling of their routine problems. Special thanks to Dr. Leonard G. Scott for his work on the Diabetes Detection Drive, to Dr. Carl Ware, Chairman of the Poliomyelitis Committee and Dr. Irvin Sussman, Dr. Frank Aitken, Dr. Benjamin Berkowitz and Dr. P. A. Ruggieri for their work in the Cardiac Symposium. To Dr. Mary Bacon, our Secretary, I owe a debt of gratitude for her infinite patience and tireless work in keeping excellent notes and minutes of our meetings. Thanks to Dr. Samuel B. Pole, for his excellent accounting and auditing of Society funds, to Dr. Paul Ayars for a splendid job of reporting on the year's activities, and to the members of the Society for the privilege given me to serve them for the past year.

Essex

Jerome G. Kaufman, M.D., President, Newark

Our Speakers' Bureau has been very active during the past year. It has arranged for more than 250 physicians to speak before lay groups since last May. We have planned programs in conjunction with Essex County Adult Schools. The Weequahic Adult School presented our Speakers' Bureau with $50 which it, in turn, presented to the Essex County Service for the Chronically Ill. Dr. S. William Kalb, Chairman of the Speakers' Bureau has done a commendable job.

Our *Bulletin*, under the direction of Dr. Frank L. Rosen, added some new features. Each hospital has submitted an article covering its special facilities. These articles ran in an interesting series throughout the year. The photograph of each new member inducted into the Society will be printed in the *Bulletin*. Our Pharmaceutical Advisory Committee contributed to the *Bulletin* by encouraging leading pharmacists to submit articles, five of which were published during the year. We hope that these have paved the way to a better understanding of the pharmacists' problems, and therefore a better pharmacist-physician relationship.

Our Essex County Blood Bank made great strides during the past year under a credit system which was adopted during 1954. Fortunately we are not now faced with the great problem of "shortage of blood," as we have been in the past.

Our Society has actively supported the fluoridation of local public water supply systems in various municipalities. As President I attended several Municipal Councils on this subject.

The Doctors' Chorus of our Society has made many public appearances during the year, and has appeared on fund raising telethons for such causes as the Rheumatism and Arthritis Foundation. The Chorus will hold a Spring Concert on May 9, 1956. This is the finest, the one, and the only Doctors' Chorus in North America.

The Diabetes Detection Drive was held in November 1955. Some 9000 "Dreypaks" were distributed to the public through P.T.A.s and industrial organizations, for testing purposes. Only 700 were returned despite the fact that the Chairman of our Diabetes Committee, Dr. William Levison, worked very hard to obtain the "Dreypaks."

Our Judicial Committee successfully settled many disputes, thus avoiding lawsuits in several instances.

Our Hospital Committee solved its meeting attendance problem by arranging a dinner meeting to which the chiefs of staff of every Essex County hospital were invited. Over 20 of the 26 hospitals were represented at this dinner. In addition, committee chairmen who wished to clear with the Hospital Committee were invited. This proved to be a very successful meeting with much accomplished.

We are proceeding with the program for a Health Fair which will be co-sponsored with various health agencies in Essex County. We have obtained the Public Service Auditorium in Newark, for the week of May 21 to May 26. Our County Society will have a booth at this Health Fair presenting:

1—Our emergency medical program.
2—Our Speakers' Bureau program.
3—Information concerning yearly routine health maintenance examinations.

Hudson

Sigmund C. Braunstein, M.D., President, West New York

Hudson County Medical Society this year occupies a place of twofold distinction among medical societies, in that one of its members, a past president—Dr. Vincent P. Butler—is now President of The Medical Society of New Jersey; and a member of its Auxiliary, also a past president—Mrs. Andrew C. Ruoff—is now President of the Auxiliary to The Medical Society of New Jersey.

Now in the eleventh month of the current administrative year, the Society continues to convene monthly—combining executive, scientific, and brief social sessions. We are indebted to Dr. Robert Rubenstein and his Program Committee for providing guest speakers during the year of the caliber of Drs. Arthur M. Fishberg, Kathleen E. Roberts, Joseph H. Burchenal, George W. Melcher, Samuel Standard, Solomon Silver, and George L. Kauer.

Other committees, too numerous to list in this summary, are functioning with customary zeal and effectiveness. Worthy of special commendation are the Judicial Committee, under the able and meticulous chairmanship of Dr. A. P. Rieman; the Diabetes Committee (which conducted the annual Diabetes Detection Drive), under the leadership of the energetic Dr. Sidney Woltz; the Salk Vaccine Committee, competently headed by Dr. Nathan J. Plavin; the Medical Economics Committee, handled with distinction by Dr. Samuel S. Schept; the Emergency and Night Service Committee, under the vigorous leadership of our president-elect, Dr. John E. Annitto; the Publication Committee, of which Dr. Harold B. Schwartz is chairman and Dr. Charles A. Landshof, editor; and the recently appointed Blood Bank Committee, under the chairmanship of Dr. Landshof. The Executive Committee, of which, as president, I have the honor to be chairman, renders unselfish and diligent service to the Society—which, may I say, is responsible in no small measure for the success and consequent sense of satisfaction of the present administration.

During the current year, the Physicians Relief Fund, to which all of our members contribute, has reached maturity and may be counted upon to provide assistance to physicians in financial need. For the benefit of our general membership, a Standard Minimum Fee Schedule for Compensation Claims has been established and is being given the publicity it requires for ultimate general adoption. The Medical Plan for Clients of the State Board of Child Welfare has been approved and adopted by the Society, with appropriate publicity. We are carrying out a policy of constant vigilance with regard to the Medical Practice Act and medical ethics in general, and have from time to time directed attention of the proper authorities to apparent violations.

The Society continues its own group enrollment in Hospital Service Plan of New Jersey, and conducts two enrollment periods annually.

On March 6, 1956, the Society adopted a resolution offered by the Radiological Society of New Jersey, requesting elimination of medical services from the subscription contract of the Hospital Service Plan and the discontinuance of payment for these services directly to the hospital; and the transfer of these services to the subscription contract of the Medical-Surgical Plan.

With the fiscal year still incomplete by two meetings, we have elected nineteen physicians to membership and have reinstated two. To our list of honorary members has been added the name of Dr. Roland J. Lynch.

We record with deep regret the death of one honorary member, Dr. Frederic J. Quigley, a past president, on December 23, 1955; and of ten active members—Dr. William J. Mathews on May 31, 1955; Dr. Vincent R. Campana on July 15, 1955; Dr. Joseph F. Londrigan on August 1, 1955; Dr. Hyman Frieman on September 19, 1955; Dr. Charles P. DeFuccio on October 9, 1955; Dr. Arthur P. Trewhella (vice-president) on November 28, 1955; Dr. Morris Grossman on December 29, 1955; Dr. Sidney N. Mandell on February 12, 1956; Dr. Vincent J. Sheeran on March 5, 1956; and Dr. Charles M. Harris on March 9, 1956.

Four of our members are in military service.

We record at this point the unprecedentedly successful Annual Dinner-Dance of Hudson County Medical Society, held in honor of its president, on January 28, 1956, at the Essex House in Newark.

My term of office comes to a close on May 1, 1956. It has proved to be a broadening and enriching experience and I am deeply grateful to have had this opportunity to be of service to my fellow physicians of Hudson County.

Mercer

Albert F. Moriconi, M.D., President, Trenton

Under the chairmanship of Dr. Howard E. Topley, Jr., and with the assistance of Drs. John L. Wikoff, Joseph T. Salvatore, and John S. Wise, four most interesting scientific sessions were arranged. Dr. A. Reynolds Crane, Pathologist, Pennsylvania Hospital, spoke on "Pulmonary Adenomatosis." Then Dr. Elmer C. Bartels, of the Lahey Clinic, Boston, addressed us on "Hyperthyroidism in the Elderly Patient." At the following meeting, Colonel Thomas A. Mattingly, Walter Reed Hospital, Washington, D. C., reviewed the cardiovascular manifestations of carcinoids of the gastrointestinal tract. At the final session, Dr. Richard B. Cattell, of the Lahey Clinic, Boston, spoke on surgery of the biliary tract.

The fourth series of the radio program, "Help Yourself to Health" was presented each Monday at 7:15 p.m. (October 3, 1955 through January 16, 1956). Details of the program were handled by Dr. Joseph A. deBlois, Chairman of our Public Relations Committee, and specifically, by Dr. Murray D. Shepp, in cooperation with members of the Mercer County Component Medical Society; the Woman's Auxiliary to the Mercer County Component Medical Society; radio station WBUD; Mrs. Nan Rednor, known to radio listeners as "Nan About Town;" representatives of the press; Mercer County Pharmaceutical Association; Mercer Dental Society; Department of State Nutrition; Central New Jersey Chapter, Multiple Sclerosis Society; Reverend Warren Howell, of St. Michael's Episcopal Church; Mr. Edward Silverglade of the Police Athletic League; Miss Helen Sheley, Superintendent of the New Jersey State Home for Girls; and Dr. James F. Albach, of the Board of Education.

Diabetes Detection Week (November 13-19, 1956) was observed very effectively in Mercer County under the chairmanship of Dr. John T. Dimun, in cooperation with the New Jersey State Department of Health; the Woman's Auxiliary; P.T.A. organizations; and the Mercer County Pharmaceutical Association.

The annual "Charity Ball" sponsored by the Woman's Auxiliary, held at the Trenton Country Club was very well attended. The proceeds were applied to the Nurse Scholarship Fund.

The feature of the Society's annual banquet, held Wednesday evening, December 14, 1955, was the awarding of service plaques to all of our living past Presidents. Physicians who served as President of the Mercer County Component Medical Society during the period 1900 to 1954 were present and received these awards. Our Annual Outing was held at the Trenton Country Club. Our guests on this occasion were members of the Mercer County Pharmaceutical Association and the Mercer Dental Society.

On February 8, 1956, the following were elected to offices for the year 1956-57:

President—Dr. Jacob M. Schildkraut
Vice-President—Dr. A. James Fessler, Sr.
Secretary-Reporter—Dr. David Eckstein
Treasurer—Dr. George A. Hess

The Mercer County Component Medical Society had matters pertaining to the Salk antipoliomyelitis vaccine on its agenda for almost a "daily diet," and the members of the Society formed a strongly cohesive unit in maintaining the front desired by The Medical Society of New Jersey and the American Medical Association.

Middlesex

Joseph F. Sandella, M.D., President, New Brunswick

January meeting:

"Cancer of the Skin—Surgical and Radiologic Aspects"—William O. Wuester, M.D., Elizabeth General Hospital.

February meeting:

"The Management of Heart Disease in Pregnancy"—Curtis L. Mendelson, M.D., Associate Professor of Obstetrics at Cornell.

March meeting:

"Physical Medicine and Rehabilitation in General Practice"—Michael M. Dasco, M.D., Director, Dept. of Physical Medicine and Rehabilitation, Goldwater Memorial Hospital.

April meeting:

"Simple, Rational Treatment of Common Skin Diseases"—Robert D. Griesemer, M.D. Dermatologic Service, Massachusetts General Hospital.

May meeting:

Annual Doctors-Dentists dinner meeting—Guest speaker: Dr. Houston Peterson, Professor of Philosophy, Rutgers.

June meeting:

Annual Dinner Meeting and Installation of Officers—Dr. Stanley Jaks spoke on "Curiosities of the Mind."

October meeting:

"Recent Advances in the Management of Coronary Artery Disease" — Simon Dack, M.D., Cardiologist, Mt. Sinai Hospital, New York.

November meeting:

Joint meeting with Pharmaceutical Association of Middlesex County — Guest Artist: Marion Page.

December meeting:

"Management of Acute Renal Failure"—Russel Elkington, M.D., University of Pennsylvania.

Monmouth

William F. Jamison, M.D., President, Bradley Beach

The Monmouth County Medical Society experienced a successful year particularly marked by informative and interesting scientific programs covering a varied number of subjects, resulting in a noticeable increase in attendance at our meetings. The usual joint dinner meeting with the Dental and Pharmaceutical Societies was arranged by our Inter-Professional Relations Committee. This affair affords an opportunity for the promotion of better inter-professional relations both at an individual and society level.

The annual winter and summer dinner-dances sponsored jointly by the Society and our Woman's Auxiliary again proved very successful with record-breaking numbers of members and guests at each. It would be timely and pertinent to commend our Auxiliary for the interest and enthusiasm they display in furthering projects of their own and the Society.

Our annual outing provided the usual features of sports and good food enjoyed by many members and guests. Occasion was highlighted by an address by the State Society President, Dr. Vincent P. Butler, and by the installation of officers.

We will once again be privileged to meet at the U. S. Army Hospital, Fort Monmouth, in April 1956 as guests of the Senior Medical Officer, Colonel Rollin L. Bauschspies and his staff. Following dinner, the scientific session will feature a program presented under the auspices of the Army Hospital staff.

We anticipate our May 1956 meeting at which prominent speakers will discuss medico-legal problems. Our guests will be the members of the Monmouth County Bar Association.

Our Child Health Committee has been active in regard to the controversial Salk vaccine situation. Following a regular meeting of our Society at which the problem was thoroughly discussed, and after several meetings of our representatives with representatives of allied health agencies in the county, a clinic project was developed for the administration of first injections of the vaccine to those unable to pay for private medical care. This utilized the facilities of seven already-established hospital and well-baby clinics at strategic locations. During February and March, clinics were held twice a month at each site and will be held once a month during April, May and June, 1956 at which time the project will be discontinued.

Vaccine was furnished by the New Jersey State Department of Health and the clinics were staffed by volunteer physicians and record keepers. Nursing services were provided by existing nursing agencies and volunteer nurses recruited at a local level.

We feel that the clinics served some purpose although we did not reach large numbers of the people the project was designed to serve. It is our opinion the present allocation of vaccine on a basis of 60 per cent to public agencies and 40 per cent to private physicians complicates the situation created by the vaccine shortage, does not afford the opportunity to all of the people to receive the vaccine and, in

effect, penalizes those able and desirous of paying for their medical care. We would still like to know "when and where can we get the vaccine."

The various committees of the Society have proved their readiness and willingness to serve when called upon. I am particularly grateful to the members of the Executive Committee for their excellent attendance at the regular monthly meetings and their interest and cooperation in solving the various problems presented to the Society.

Passaic

Joseph R. Jehl, M.D., President, Clifton

During the past year the Passaic County Medical Society has had regular monthly meetings. At most of these, there have been discussions by specialists on scientific subjects. At two there were discussions of a cultural and socio-economic nature. The membership has continued to grow and there are now 573 members. A special meeting was called to discuss the stand of the Society on poliomyelitis immunization. A suitable resolution was adopted.

Our Medical Society Building is in good financial condition. It is occupied not only by the executive offices of the Society, but also by the Passaic County Chapter of the American Cancer Society and the Medical-Dental Service Bureau. The meeting room is used by various health groups and agencies with whose aims we are in sympathy, and whose programs we hope to further. The Woman's Auxiliary also has space here, which is also the office of the Homemaker Service.

During the past year, graduate programs have been held for the members and hospital house-staffs, in the fields of obstetrics and orthopedics. An extensive program on hand injuries was offered in the fall.

Representatives of the Public Relations Committee and the Welfare Council met with representatives of the press again this year to discuss problems of common concern. This dinner-meeting has been very successful in improving medical-press relationships and is recommended as a program to all county societies. It is hoped to arrange a similar dinner with the congressmen, assemblymen and freeholders to further a more complete understanding of the relationships of our common problems.

This year, for the third time, the Society in cooperation with the *Herald-News* held two medical forums in Clifton High School. These were well attended by the public, for whom they were planned. The subjects discussed most ably by the panelists were "Alcoholism" and "Geriatrics."

After repeated consultations between the Board of Chosen Freeholders, representatives of the Passaic County Chapter of the Poliomyelitis Foundation and representatives of the Passaic County Medical Society, a pavillion was opened this year for acute contagious diseases at Valley View Hospital. It was the aim in this venture to make certain that facilities will be available for the adult patients with poliomyelitis, who had no facilities for care in the local general hospitals in the past, although the children had been cared for at St. Joseph Hospital, Paterson.

Salem

Eugene T. Pashuck, M.D., President, Salem

The Salem County Medical Society had an active year, marked by progress, with no serious internal differences of opinion.

Our major project for the year has been a revision of the Constitution and By-Laws. This was finally accomplished at our March meeting and copies of the new Constitution were printed for distribution.

Much time at our meetings was spent in discussing the poliomyelitis immunization problem. We resolved the situation by stating in public announcements that, although we do

not approve of free clinics with no means tests being applied, we felt that it was urgent that all children receive this vaccine as soon as possible, and members of the society administered the vaccine to large numbers of children in several clinics.

Our monthly speakers have been thoroughly interesting, and have given talks on a variety of subjects.

Five new members, Drs. Sungenis, Boyer, Kass, Taylor and Croft were elected to the Society.

Dr. Suter has led an active Public Relations Program. Eight members of the Society formed a speakers' panel which lectured to the First-Aid groups in various communities; their talks included such subjects as: obstetrics, cardiac problems, use of oxygen, transportation of patients in shock, with fracture, care of psychotic emergencies, and contagious precautions. Our week-end coverage system is working well, since our Grievance Committee has had no complaints or letters complaining about poor medical coverage.

Dues have been raised from $10 to $15 to cover necessary society activities.

Our year closes, as usual, with the Annual Shad Dinner at the Salem Country Club. This traditional affair has become one of the high points of the year.

Sussex

Dorsett L. Spurgeon, M.D., President, Newton

The Sussex County Medical Society began its year by consolidating and streamlining its various committees. We have been successful in correlating the committees so that they now are workable in our small county, with projects and problems handled mostly through them. We have had our regular quarterly meetings, one special meeting, and our year ended with a dinner meeting on May 8.

Problems in the administration of Salk vaccine consumed a major part of our official business. We have followed, in general, the policies recommended by The Medical Society of New Jersey, with respect to the Salk vaccine. Due to the shortage of commercial vaccine and the distribution of the vaccine principally through the Boards of Health, we have offered our services to these Boards for administering the vaccine this spring. We have carried out the state programs on diabetic detection and conservation of vision through our county committees.

The Education and Postgraduate Committee provided speakers for scientific programs at each of our meetings. We have cooperated with the Adult Education Program established by the Newton School and set up an educational program on "Modern Trends in Medicine." A subject is being discussed by one of our members at ten weekly meetings this spring for general public education. Plans are also being formulated for a Graduate Course for the members of our society this spring. Our Public Health and Welfare Committee, has, through the County Agencies, worked out a satisfactory program for medical coverage of the county welfare patients at "The Homestead."

A book on medical public relations by James Bryan has been donated by the Society to the libraries of each of the three hospitals in the county as a public relations project.

The Medical Society entertained the County Bar Association at a dinner meeting in reciprocation for a meeting initiated by that Association last year to promote better inter-professional understanding and relations.

One new member, Dr. Earl Miles of Andover, N. J. has been added to our rolls. We are fortunate in having no loss of members this year.

Union

Carl G. Hanson, M.D., President, Elizabeth

The outstanding social event of the year was the reception given for Dr. and Mrs. Lance during the annual meeting of The Medical Society of New Jersey. It was a most enjoyable affair. The annual outing of the Society was held at the Echo Lake Country Club in Westfield and was the most successful one ever held. The President gave a small party at the beginning of our season for the members of the Executive Committee and their wives in order that the new members of the committee might become better acquainted with the other members of the committee.

This year we are working under the new revised Constitution and By-Laws, which provides that all new members (except those who have had membership for two years in another county society) shall be associate members for two years and serve on the Emergency Medical Service panel. This has proved very satisfactory and the service is now working well. We have elected 23 new members this year, including 15 associate members.

The meetings this year have stressed socio-economic problems and the members attending have been most interested and active on the many discussions presented.

Outstanding work has been rendered by the Committee on Constitution and By-Laws, Civil Defense, Medical Practice, Workmen's Compensation, Judicial, Diabetes, Salk Vaccine, Publication, Public Health, Child Health, Outing, Program, State Committee Headquarters and many others. Members were most cooperative in carrying out their various assignments.

The House Committee which formerly had to do only with proposed project of a permanent future headquarters has now taken over the duties of all matters pertaining to our present headquarters and personnel policies.

A new "Indoctrination Committee" has been created. It will be of invaluable assistance for new members to advise them as to their responsibilities and privileges as members of organized medical societies. Many problems face new members starting in private practice and this committee, we feel, will help resolve many of them.

We sustained a great loss in the death of Dr. Watson B. Morris of Springfield, a former president of the County Society and a former President of The Medical Society of New Jersey. He was active in the County Society and attended a special meeting of the Executive Committee in December to discuss Salk Vaccine problems.

One new project the Child Health Committee had hoped to carry on this year was accident prevention in children. Not much has been done to date but the State Board of Education has recognized our aims and approved wholeheartedly. More children are killed and maimed than in any other single category. It is also logical to assume that a child educated in safety becomes a much safer adult.

The Woman's Auxiliary when called upon were most helpful as always. We could not have carried out our programs and projects without their assistance. To them our sincere appreciation.

Administrative activities have been carried out more smoothly and efficiently this year with the addition of an assistant to the Executive Secretary. With our membership growing so rapidly there are many matters that come up not only in regard to the physicians but more demands for services are made by the general public. Mrs. Brown with her tact and efficiency in performing her many tasks has proved invaluable to the Executive Secretary and to the Society. On two occasions she had to take complete charge of the office on sudden notice and our work was carried on without interruption during that time.

This year the Medical Societies' Executive Conference held its First Institute in Chicago. Miss Rogers attended the session. She brought back many interesting suggestions and ideas for future programs and projects. A number of suggestions made at the Institute are already being carried out by our staff and membership. New Jersey sent four Executive Secretaries and they held several informal meetings to discuss their own mutual problems and ideas.

My appreciation to the members of the Executive Committee who gave so much time and effort to this past year's work. There were many demands made upon them and without the full cooperation received, our work could not have been carried out.

Book Reviews • • •

Signs, Language and Behavior. By Charles Morris. 1955 Prentice-Hall, New York. Pp. 365. ($5.00)

Since the author uses terms like "valuatum" (which is defined as "significatum of appraisor"), a glossary is necessary. I tried to figure out what "plurisituational" meant by using the glossary. Well, "plurisituational" is here defined as a "sign that is not unisituational." And "unisituational" is defined as a "sign that signifies a given significatum." And what is "significatum?" Here it is: "the conditions such that whatever meets these conditions is a denotatum of a given sign." Ah—we're getting hot on the trail. But what is a "denotatum?" Here is the definition: "Anything that would permit the completion of the response-sequences to which an interpreter is disposed because of sign." Get it?

VICTOR HUBERMAN, M.D.

The Complete Medical Guide. Benjamin F. Miller, M.D. Pp. 914. New York. Simon and Schuster. 1956. ($4.95)

That word "complete" will scare off any doctor since no volume can ever be complete. Still, this big book does contain a vast amount of data not found in the traditional home medical guide. It has material on Blue Cross, a glossary of medical terms, a list of first-aid and home medicine-chest material, the addresses of voluntary health and welfare organizations, hints about climate, vacations, emotional attitudes and housing problems. It covers most of the major diseases. The information on the whole is correct. The text is aimed at making the layman a better patient not an amateur doctor. It is too bad that such relatively benign disorders as infectious hepatitis are included in the chapter called "The Killers."

Dr. Miller is an internist with a research orientation and a real talent in placing words end to end. The book is solid and may be safely recommended to the intelligent patient. Of course there are always those doctors who believe that the less the patient knows (or thinks he knows) about medicine, the better off he will be. But unless you have this crotchet, you will find Dr. Miller's book a good reference work for the inquiring layman. Any physician called on to deliver public lectures will be more comfortable if he has this volume at hand. It suggests many topics for such lectures, and points out how some rather complicated medical concepts may be spelled out for the intelligent, but medically naive, patient.

HERBERT BOEHM, M.D.

Management of Addictions. Edited by Edward Podolsky, M.D. New York 1955. The Philosophical Library. Pp. 411. ($7.50)

Dr. Podolsky has discovered an easy way of getting your name on the spine of a book. Tear 3 dozen articles out of old medical journals, staple them together, write a pious foreword, and behold: a book! Ordinarily the editor of an anthology classifies the articles, writes notes about them, weaves them into some pattern, writes liaison material between the separate chapters. But Dr. Podolsky is a non-editing editor. He does none of these. To add to the confusion, there are no running chapter heads and there is no subject index. If you want to find out something about one phase of treatment, for instance, you have no choice but to sweat through the 35 articles one at a time. Frankly, it isn't worth it. Furthermore, the editor does not tell you from what journal each article came. Instead, he lists the journals *en masse* but doesn't tell you what paper came from what journal. If he did you could get reprints of those you wanted instead of paying $7.50 for a collection of papers written at different times by different authors and then strung together like beads.

HENRY A. DAVIDSON, M.D.

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TUBERCULOSIS *Abstracts*

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ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

VOL. XXIX May, 1956 No. 5

THE TUBERCULIN TEST

By Floyd M. Feldmann, M.D., Medical Director, National Tuberculosis Association, NTA BULLETIN, *November,* 1955.

Any community tuberculin testing project can best be handled by a central committee with wide representation including the medical society, the tuberculosis association, the hospitals, the health department, the schools, the social agencies, the nursing groups, the Parent-Teachers Association, and any others who may have some direct or indirect interest. After a general plan has been agreed upon, a smaller group can serve as an advisory group but better results will be obtained if everyone interested directly has a chance to be fully informed and has a part in deciding on the plan.

The plan should include provision for everything from the educational campaign through a complete follow-up and report. Adequate records will be indispensable for final evaluation. Sample forms are now available from the Social Research Division of the National Tuberculosis Association.

A well worked-out plan for informing the whole community about the tuberculin testing program is a necessity and also affords an opportunity to extend interest to the entire tuberculosis control effort. Expert guidance from professional health educators should be sought and represented on the central planning committee.

All reactors should have chest x-rays annually, although few white children up to age 12 will have demonstrable lesions. This may become more important if the use of chemotherapy for primary lesions becomes general. This preliminary x-ray check of reactors is only the first step in the follow-up program and will usually reveal few or no active cases.

The next and more difficult step is the examination by tuberculin test, x-ray, or both of all contacts of new reactors found. This is more successful among young children who have fewer contacts with adults and most of these are in the home. Practically, this search should be extended to reach the contacts of older children and adults who have recently become tuberculin reactors.

At present the available data are inconclusive both as to prevailing infection rates, trends in these rates, and the efficiency of various tuberculin testing programs in discovering new cases. Efforts are now being made to collect what information may exist but this has not so far been analyzed and reported. Plans for new studies are contemplated.

However, scattered reports provide a basis for some speculation: 1. Tuberculin infection rates are declining in most places. Reactor rates in schools and colleges are lower in recent years. 2. Infection rates vary considerably geographically and by age and sex. Rates are higher in more densely populated areas and increase up to age 60-70, although females have lower rates than males after age 30. After age 60-70 there is a decrease in reactor rates, but they remain high. There is some indication that new infection rates taper off rapidly after age 30-40 and that the high rates in the older ages are the result of high infection rates in the years when they are young. 3. Case-finding results using the tuberculin test as a preliminary screen are extremely variable but usually disappointing.

There are some theoretical reasons for the fail-

ure of tuberculin test programs to uncover larger numbers of previously unknown active cases: 1. In areas of low incidence and low prevalence of cases, factors at present not specifically identified, delay or prevent the development of infection into significant disease. 2. Well conducted health department programs with efficient continuous follow-up of old cases and new cases with their immediate contacts are already discovering most of the new and relapsing cases. 3. With the shift of average age of active cases to an older level, there is less likely to be a school age child in a home where a person with active tuberculosis resides. 4. Many children who live in a home with a tuberculosis patient do not become infected. 5. Many children are probably infected by casual contacts not easily traced.

Although the individual tuberculin test may seem inexpensive, the cost of a program can be very high for the results obtained in the control of tuberculosis. Material costs are low but all those tested must be seen at least twice by someone with professional training and a variable number will require subsequent x-ray examinations. The follow-up of contacts also requires large amounts of professional time and travel. Often the professional time is donated or hidden in the budget of another agency but it is a real cost and should be taken into account.

Although no one can place an absolute value on the benefit to the community in finding a case, the costs of a case-finding program must be weighed against other possible procedures which might be more efficient. A rational decision can only be made by a careful study in each community. Programs should be well planned with subsequent evaluation in mind.

Tuberculin tests are valuable in diagnosis, to determine the status of tuberculosis control in a community, and perhaps as a screening tool in case-finding. Although several techniques are in use, the intradermal test with P.P.D. is preferred. Patch tests can be used successfully but have definite disadvantages.

For determination of rates of infection and rate trends in a community, the best information can be obtained by testing the whole population. In decreasing order of efficiency, the test program may consist of a scientific sampling of the whole population, all school children and school employees, and selected school grades.

An important part of the preparation for a tuberculin test program which is valuable for both its immediate and long-range benefits is an extensive educational program for the whole community with as wide participation as possible.

The follow-up program is difficult and expensive. It must include examination of contacts of reactors as well as x-rays of reactors, and must be planned for in advance.

Accurate data on the case-finding potential of programs using the tuberculin test as a screen are almost totally lacking. Those who may have such data are urged to make them available through publication. Current tuberculin testing programs should be thoroughly evaluated and a few pilot studies should be initiated. Special assistance in planning such studies is now available through the NTA Division of Social Research.

Editor's Note: This is the second of two abstracts on the tuberculin test—the first of these was the April issue of Tuberculosis Abstracts.

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1. DeWeese, D. D.: Symposium: Medical Management of Dizziness. The Importance of Accurate Diagnosis, Tr. Am. Acad. Ophth. *58*:694 (Sept.-Oct.) 1954.
2. Jackson, C., and Jackson, C. L. (editors): Diseases of the Nose, Throat, and Ear, Philadelphia, W. B. Saunders Company, 1945, pp. 368; 414.
3. Queries and Minor Notes: Ménière's Syndrome, J.A.M.A., *141*:500 (Oct. 15) 1949.

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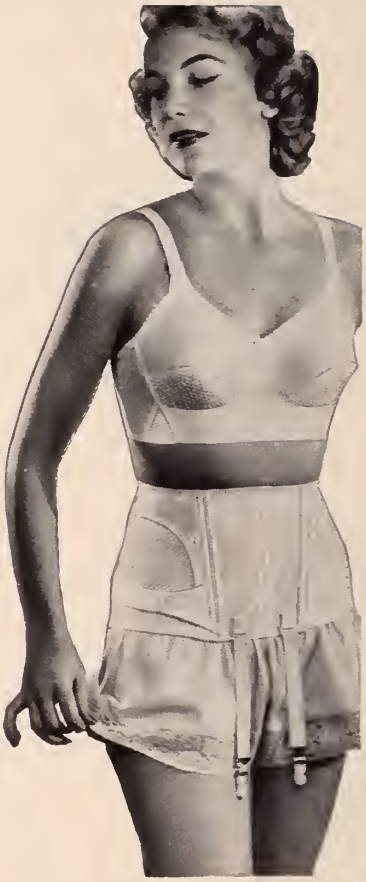
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*McLester, J. S., and Darby, W. J.: Nutrition and Diet in Health and Disease, ed. 6, Phila., Saunders, 1952, p. 195.

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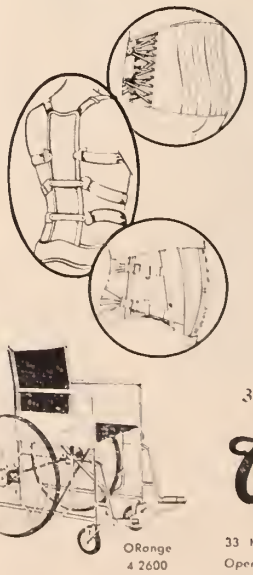
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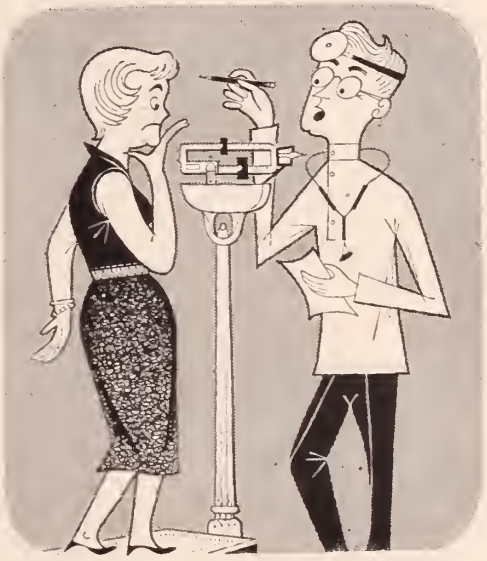
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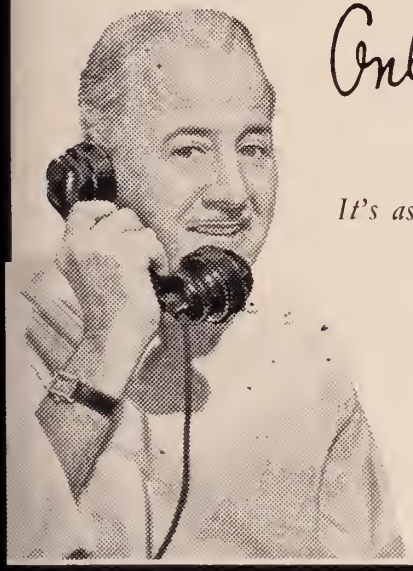
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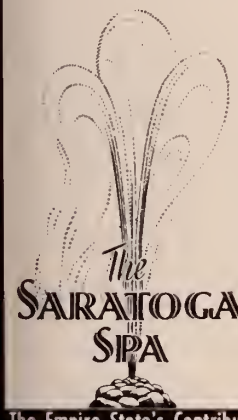


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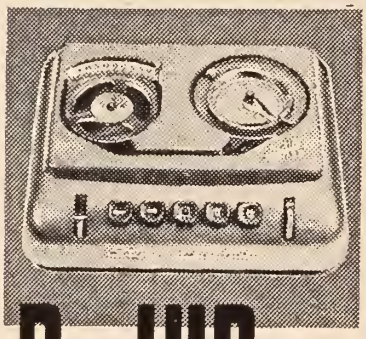
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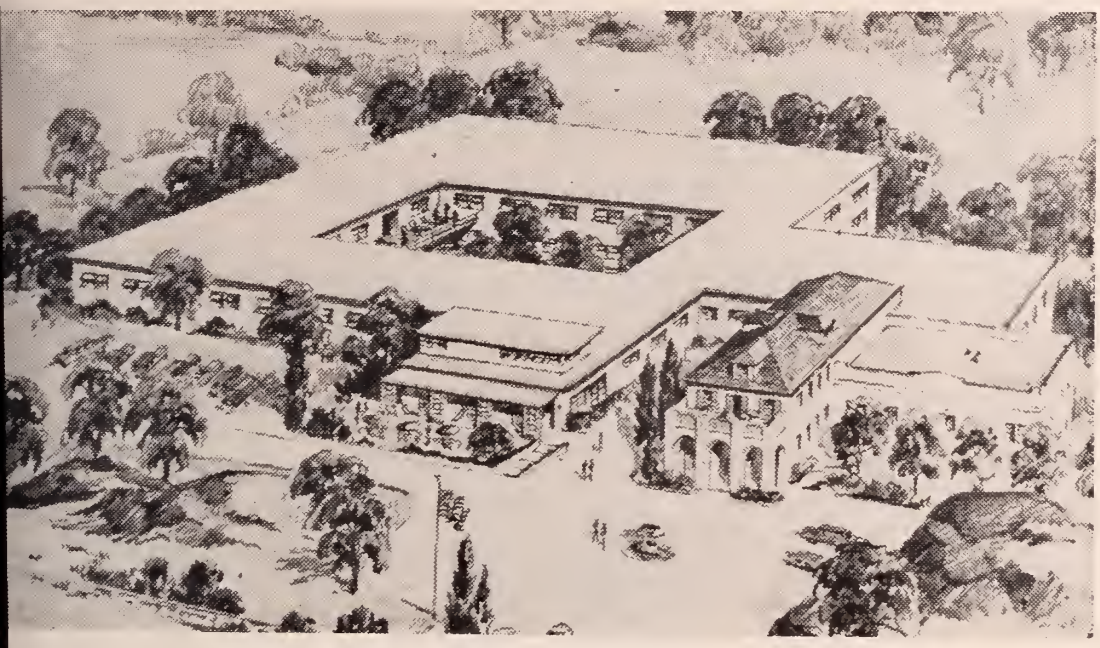
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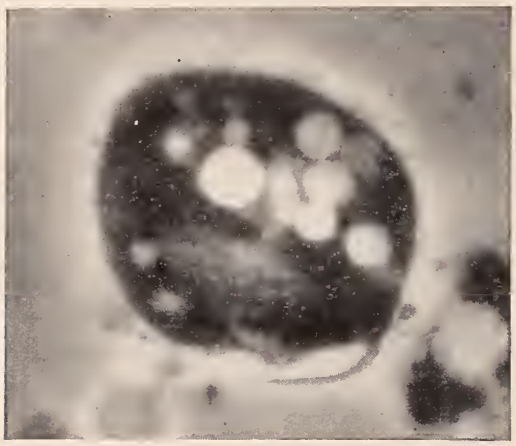
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1. Davis, C. H.: Am. J. Obst. & Gynec. 68:559 (Aug.) 1954.
2. Davis, C. H.: West. J. Surg. 63:53 (Feb.) 1955.
3. Davis, C. H.: J.A.M.A. 157:126 (Jan. 8) 1955.

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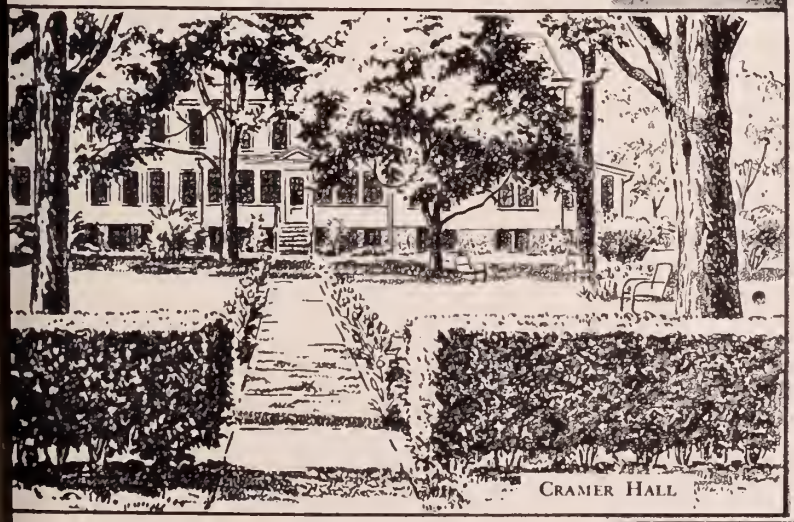
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[1]Albertson, H.A. and Trout, H. H., Jr.: *Antibiotics Annual* 1954-55, Medical Encyclopedia, Inc., New York, N.Y., 1955. pp. 599-602.

[2]Prigot, A.; Whitaker, J. C.; Shidlovsky, B. A., and Marmell, M.: *ibid*, pp. 603-607.

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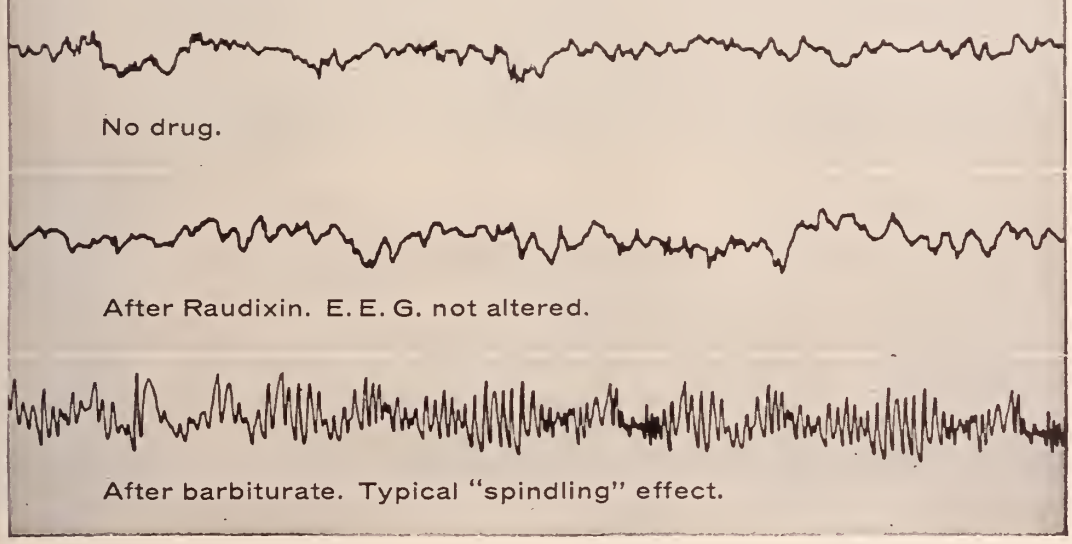
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1. Seifter, J., et al.: To be published. 2. Fazekas, J.F., et al.: M. Ann. District of Columbia 25:67 (Feb.) 1956. 3. Mitchell, E.H.: J.A.M.A. In press.

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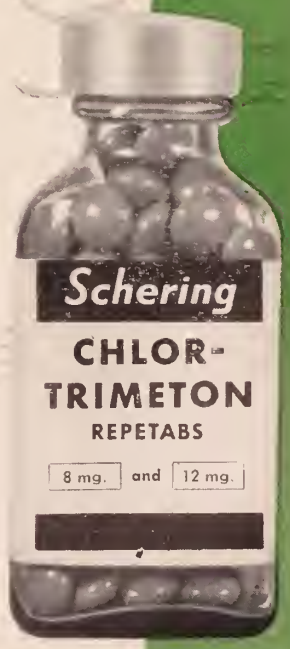


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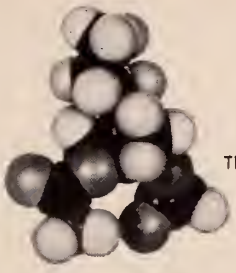
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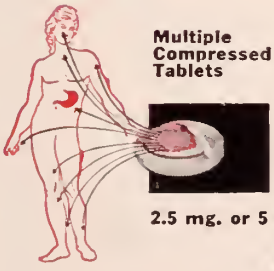
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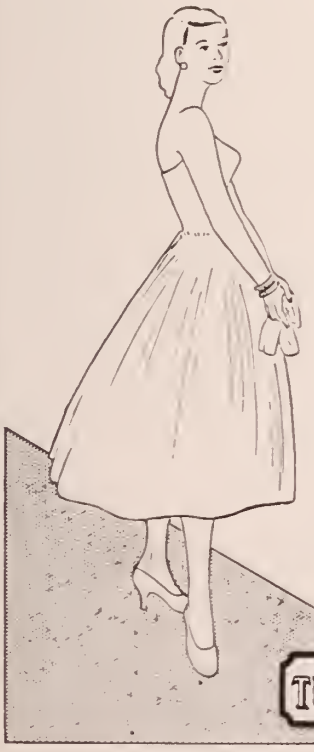
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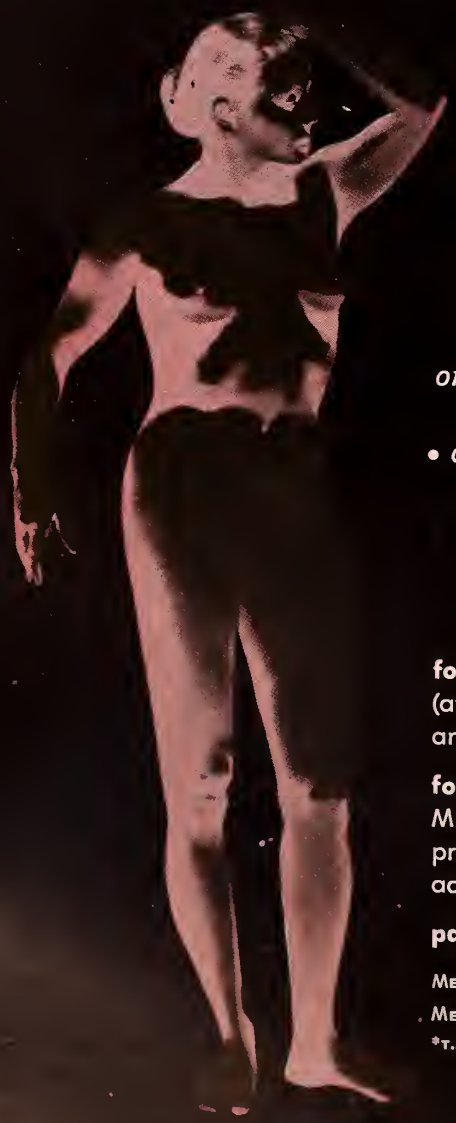
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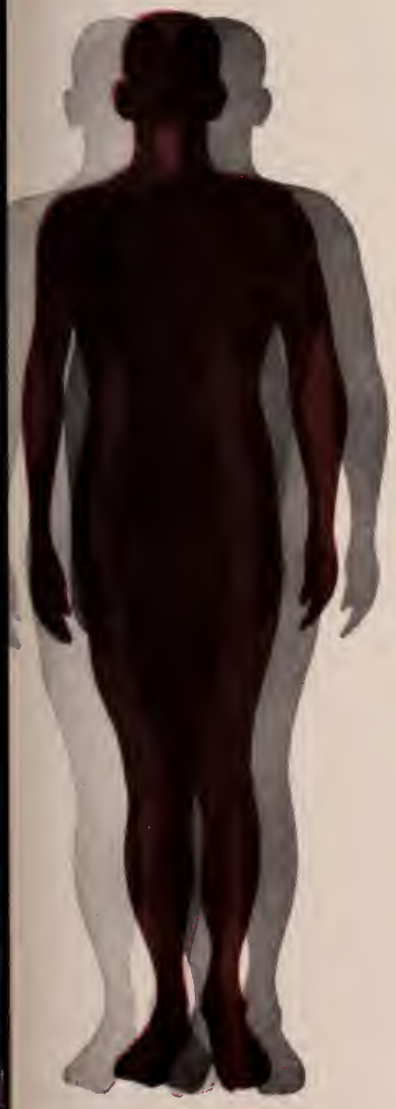
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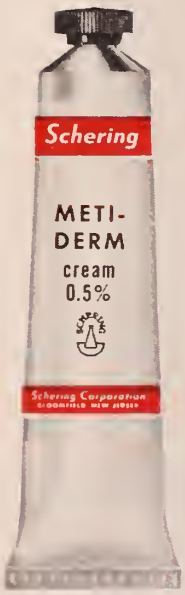
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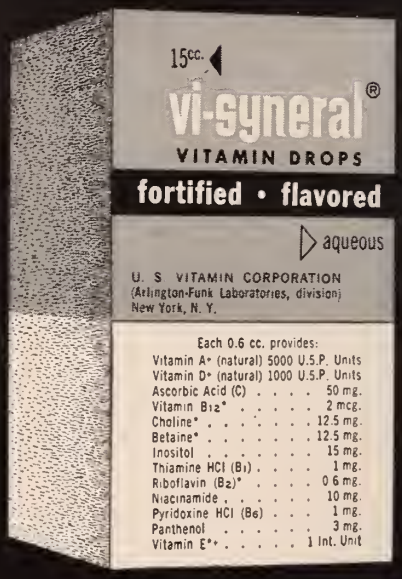
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Lewis Canfield Fritts is a big man from a small town. He is, furthermore, our first 20th century-born President. That event—his birth—occurred in 1903 in Hoboken.

He won his B.S. degree from Pennsylvania State College in 1925. He then did graduate work in science for a year and entered the Jefferson Medical College in 1926. He was graduated from Jefferson in 1930. While in Philadelphia, he won one of the coveted "Blockley" internships — the famed two-year internships at the Philadelphia General Hospital. In that period he developed a taste and talent for surgery, and was chosen to be a Fellow in Surgery at the Cleveland (Ohio) Clinic.

In 1935, Dr. Fritts finished his surgical Fellowship in Cleveland and came to Somerville to practice. Dr. Fritts is, he will tell you, and

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tell you proudly, a family doctor. He is also a Fellow of the American College of Surgeons, senior surgeon at the Somerset Hospital, and a member of the New Jersey Society of Surgeons.

Dr. Fritts is, in every sense of the word, a leader. He takes to leadership like a duck to water. He was soon recognized as such (as a leader, not as a duck) by the Somerset County Medical Society which enthusiastically placed him on the presidential succession ladder in that county society. His energies and activities however, rapidly radiated beyond the pleasant frontiers of Somerset. He somehow became involved with the Woman's Auxiliary and served for some time as chairman of our Society's Advisory Committee to the Auxiliary—a post he filled with satisfaction to both organizations. Then he was advanced to the chairmanship of the important Subcommittee on Medical Practice and finally tabbed for service as Second Vice-President of The Medical Society of New Jersey.

Dr. Fritts is married to the former Marion Snyder. The couple have a son and two daughters. Dr. Fritts does not limit his activities to medical organizations. He is also active in civic affairs and has served as president of the Somerville Rotary Club. Somerville knows a leader when it sees one.

The Romans Had a Word For It

The Romans had a word for it: *placebo*: "I shall please." Just as every physical disease has an emotional component, so every drug has an emotional overtone. Every doctor can tell of patients who found relief (or an untoward effect) so soon after taking the drug that this must have been emotional not pharmacological. Turn to the medical books or journals of a few decades ago and you will see good results reported with drugs now known to be impotent. The doctors who administered those drugs were men of good faith, who would have denied that they were giving placebos. So it is with all of us. We can rarely disentangle the pharmacologic from the emotional effect of a drug.

In spite of all this, there are those who think that the intentional administration of placebos is immoral, a sort of fraud on the patient. Since the relief of symptoms is a noble aim, it is hard to see why this should be so—unless, indeed, the doctor has affirmatively misrepresented. It would, admittedly, be immoral to give a hypodermic of sterile water and tell the patient he was getting serum made from the blood of Arabian race horses. But the patient seldom demands a bill of particulars. In fact his unfamiliarity with the medication has always been part of the magic of medicine—which is, perhaps, one reason doctors and pharmacists make poor patients.

A placebo does exercise a physiologic effect. By inducing rest, calming anxiety, and reducing stress, it sets in motion a physiologic chain reaction. It is naive to ascribe the results exclusively to some wraith-like "psychogenic effect" floating disembodied in free air.

A placebo is, in a sense, a precision tool. There is a way of writing a prescription, a way of handing it to the patient, a way of indicating what effect it will have. And as these ways vary, so does the effectiveness of the placebo. Here lies scope for the doctor's artistry. In such a situation, the doctor's own personality becomes part of the placebo.

Only the inexperienced assume that vulnerability to a placebo is dependent on the patient's intelligence or sophistication. Indeed, it might be argued, that only a stupid person would be skeptical about the potency of a drug. ("How could a little pill in my mouth affect a big pain in my leg?" asked one not-too-bright patient).

So the placebo—given with restraint and artistry—has a definite place in every doctor's formulary.* Don't sell it short.

*Not, you will notice, in his armamentarium—Editor.

I. J. Sobel, M.D.

Passaic

Hypertension: A Geriatric Problem

The advancing front of medicine has so prolonged life that geriatrics will be the core of tomorrow's practice. This article on the geriatric aspects of hypertension is, therefore, especially timely.

Nearly 100,000 people die annually in the United States[1] as a result of heart failure due to increased blood pressure. Essential hypertension has been classified by Page and Corcoran[2] as follows:

1. Prehypertension occurring in youth with hereditary factors characterized by transitory elevation of arterial pressure. These persons may develop true hypertension.

2. Neurogenic hypertension in which elevated blood pressure persists over long periods with minimal evidence of progressive vascular disease in the heart, brain, eyes or kidneys. In this group there are many individuals with moderate to marked emotional instability and central nervous imbalance. The symptoms in this group are varied, but cardiac damage is usually slow. Such patients tend to respond well to general therapeutic measures and may respond poorly to more drastic measures such as sympathectomy.

3. Established hypertension which includes a large group of patients whose disease is almost free of symptoms until some complication, such as heart failure, brings them to the physician's office. This group must be carefully examined to prevent progressive damage which will interfere with successful treatment.

4. The last group, malignant hypertension, in which there is rapid arterial involvement with encephalopathy, weight loss, visual and renal involvement.

General measures have proved of great value in slowing the rate of progress of essential hypertension in all but its most severe form. Of great importance is the patient's acceptance of his disability and his willingness to organize his activities with proper regard for his condition. This means moderation in work and play, with excess only in rest and recreation of the more passive type. Primary purpose is to secure calmness and eliminate stress. Emotional guidance must be maintained throughout treatment. Symptoms such as fatigue, headache, palpitation, dizziness, may appear out of all proportion to the severity of the disease in those whose personality structure manifests great anxiety. Constant reassurance and discussion of problems are necessary. Such patients may require more frequent visits so that minor symptoms may not give rise to larger emotional disturbances. The combination of reassurance and drug therapy is surprisingly effective in controlling these hypertensives. Diet plays a role, especially when the patient is overweight, and restriction is extended to stimulants such as coffee, tea, tobacco and alcohol. With the development of more effective hypotensive drugs the trend in therapy has moved away from sympathectomy and rigid diets.

1. White, P. D.: Heart Disease, 1951, New York, The Macmillan Company, 1951. Pp. 464, 475, 479, and 484.

2. Page, I. H., Corcoran, A. C.: Arterial Hypertension, Its Diagnosis and Treatment, Ed. 2, Chicago 1949. The Year Book Publishers.

Freis [3] believes that antihypertensive drug therapy is now the most effective of all the forms of treatment. But such drugs should be administered carefully and dosage readjusted. Great emphasis is placed upon the importance of securing basal blood pressure and some physicians believe that home recordings should be required. Drug therapy should be pursued vigorously to determine whether the desired therapeutic effect can be obtained with a minimum of side effects.

THE drugs advocated at various times literally number in the hundreds. Many of these have been downright dangerous. Orthostatic hypotension may be as serious as hypertension. Sedatives, though non-specific, may have highly beneficial effects. Dihydrogenated ergot alkaloids of the ergotoxine group* are demonstrably depressor by central and peripheral action and cause hemodynamic changes which relieve many aspects of hypertensive disease. They are particularly useful in the control of hypertensive crises. In view of the fact that various mechanisms are involved in the pathogenesis of high blood pressure, rational drug therapy must be directed toward each of the various factors. Rothlin [4] has shown that dihydrogenated ergot alkaloids provide a multiple approach by virtue of their ability to lower the blood pressure by central and peripheral vasodilator actions. Vasodilation is produced by:

1. Central depression of vasomotor tone.
2. Central inhibition of proprioceptive cardiovascular reflexes and,
3. By protection against adreno-sympathetic vasoconstrictor impulses in the vessels themselves.

Stress reactions are combatted by virtue of a central dampening effect on psychic and autonomic functions and a centrally induced bradycardia.

The most important criteria in selecting cases suitable for hydrogenated ergot alkaloids are the degree of renal damage and status of the ocular fundi. For example, Wilbrandt [5] in 200 hypertensive patients treated with the drug for a period of at least three years, showed that when renal function was intact, subjective improvement might be expected even in patients with Grade III and Grade IV fundi.

MATERIAL AND METHODS

ONE hundred and fifteen ambulatory patients were studied. Thirty-five were males and eighty were females. Eighty-four of the total number fell into age groups between 50 and 80 years. In the youngest group (ages 20 to 30) there were only three; the oldest (ages 80 to 90) numbered four. Many occupations were represented but most patients were sedentary or moderately active, a high proportion (59 per cent) being housewives.

In all instances, a careful history and physical examination were done as well as necessary laboratory tests. Contributing factors such as emotional stress were elicited. Particular attention was focused on diseases that tend to produce cardiovascular changes such as diabetes and nephritis. Coexisting diseases were multiple, the most frequent being: arthritis (12), cardiovascular disease with or without decompensation (12), left axis deviation (69), psychosomatic disorders (19), menopause (17), recent surgery (9), obesity (8). Nephritis and arteriosclerosis were noted in only two and three cases respectively; diabetes in ten patients. The following were infrequent; parkinsonism, coronary disease, hemiplegia, allergy, glaucoma, alcoholism, multiple sclerosis and epilepsy. Diet was such as to insure low sodium intake and in the case of overweight, a low calory diet consisting of 900 to 1000 calories (C80, P60, F35).

Systolic blood pressure at the initial visit ranged from 140 to 250; diastolic, 90 to 140.

This group of 115 patients presented the following chief complaints; anxiety and "nervousness" (45); headache (42); dizziness (34); precordial discomfort (28); insomnia (20); weakness (18); gastric symptoms (14); arthritic pains (14); shortness of breath (13);

*Commercially available as Hydergine®.

3. Freis, E. D., in Conn, H. F.: Current Therapy 1955, Philadelphia, Saunders, P. 124.
4. Rothlin, E.: Bull. schweiz. Akad. d. med. Wissensch. 2:249 (1946).
5. Wilbrandt, R.: Angiology 4:183 (June) 1953.

and flushing (10). Less frequently, the chief complaint was sweating, ankle edema, numbness, tingling, tremor, nose bleed, spots before the eyes, tachycardia, urinary symptoms, ringing in the ears, fainting and loss of memory. Fundus examination of the eye revealed retinal arteriosclerosis or other retinopathy with the following frequency:

90—Grade I
18—Grade II
6—Grade III
1—Grade IV

While the severity of *initial* complaints seemed to bear no direct relationship to the blood pressure level, it was subsequently noted that as the blood pressure increased, so did subjective symptoms.

The hydrogenated ergot alkaloids were usually administered after the patient had rested in a recumbent position for at least one-half hour. Office facilities provided five cheerful rooms with specially built ceiling to resist noise. Following injection of the drug, the patient relaxed on a couch for one hour. At the end of this rest period, blood pressure was again taken. The patient was then asked to sit or walk about for 15 minutes. Then another blood pressure reading was taken. Each patient was afforded the benefits of supportive psychotherapy for periods of at least one-half hour twice weekly. Discussion with other patients receiving the same treatment was regarded as a form of group psychotherapy.

DOSAGE

THE amount varied from 1 to 2 cubic centimeters of hydrogenated ergot alkaloids intramuscularly, depending on the severity of the case. Injections were repeated daily or every other day for the first two to three months and gradually decreased to weekly or bi-monthly injections. Patients manifesting a return to normal blood pressure after a few treatments, were discharged and encouraged to return at monthly intervals for six months and finally every two to three months. It was important to adjust the dose to the individual case in view of the wide variation in response. Patients requiring hospitalization for heart failure, coronary artery disease or cerebral vascular "accident" were treated more intensively. One cubic centimeter of hydrogenated ergot alkaloids was administered subcutaneously, intramuscularly or intravenously every 4 hours as long as systolic pressure remained at 170; diastolic at 90 to 110. As systolic pressure fell to 150 to 160, dosage was gradually reduced to once or twice daily. At home all patients received one sublingual tablet of the drug two or three times daily and were requested to lie down for 30 to 60 minutes in the morning or after lunch. Dosage was adjusted until the maximal relief of subjective symptoms was obtained. Some of the patients (9 per cent) also received rauwolfia alkaloids 2 or 3 times daily. A few patients (one per cent) received veratrum or nitrite drugs.

DISCUSSION AND SUMMARY

THIS series re-emphasizes the importance of hypertension as a geriatric problem. The beneficial effects of hydrogenated ergot alkaloids in the treatment of patients of advanced age are well set forth in the following studies:

Popkin[6] noted improvement in a large proportion of patients suffering from such subjective and objective symptoms as: dizziness, headaches, weakness, fatigue, stiffness of the extremities, edema of the legs, angina, dyspnea, intermittent claudication, poor adaptation to cold, loss of memory, increased irritability and a lack of the general sense of well-being. Chief improvement noted was in the sense of well-being.

According to Winsor[7] "the drug seems indicated especially in elderly patients who show irritability and restlessness." Patients with advanced cerebral arteriosclerosis noted a slight improvement in memory and ability to concentrate and to adapt themselves better to their environment. Winsor[7] also found that typical and atypical headaches associated with arteriosclerotic or essential hypertension were partially or completely relieved with the sublingual administration of hydrogenated ergot alkaloids in 86 per cent of his cases.

6. Popkin, R. J.: California Med. 72:108 (Feb.) 1950; Am. Pract. & Digest Treatment 3:532 (July) 1952.

7. Winsor, T.: Am. J. M. Sc. 224:42 (July) 1952; Geriatrics 8:636 (Dec.) 1953.

Jeffers[8] has selected the hydrogenated ergot alkaloids as safest in hypertensive crises. He recommends a dose of 0.6 milligrams* intramuscularly every 4, 5 or 6 hours as required for systolic blood pressures of 200 or more. He found side reactions to be minimal and attributed the effectiveness of the hydrogenated ergot alkaloids to reduction of cerebral vascular resistance.

The greatest proportion of subjects in the present series were between the ages of 55 and 70. Many in this group were discovered to be hypertensive during the course of a routine examination. They disclaimed any symptoms suggestive of hypertension. It is possible that these patients had felt "below par" for many years and had disregarded such symptoms as headache, dizziness, joint pain, or hyperirritability. Some presented themselves only when alarming symptoms occurred, *e.g.*, anginal pain, precordial discomfort, epistaxis or blurred vision. The following were the most frequent reasons for consulting the physician: emotional tension, headache, dizziness, precordial discomfort, insomnia and exhaustion. It is apparent that treatment must also be directed toward relief of symptoms regardless of the level of blood pressure. Although effective lowering of blood pressure has been obtained with hydrogenated ergot alkaloids, their chief value rests in their ability to produce a greater feeling of well-being and in many instances, to provide complete relief of subjective symptoms. A drop in systolic blood pressure of 20 to 40 millimeters and in diastolic of 10 to 15 was not unusual following injection of one or 2 cubic centimeters of the drug. After the patient had sat upright or walked about for a few minutes a further drop of 5 to 15 millimeters was often noted.

Excessive hypotension never occurred. This was because of the care taken to make the change from a recumbent to an upright position a gradual one. Also important was the very low toxicity. The value of supportive and group psychotherapy was consistently seen. Careful discussion of the individual's life situation and personal problems did much to

TABLE OF RESULTS

Age Group	No. Cases	Retinopathy	Impaired Renal Functioning	Range of Initial (resting) Blood Pressure		Range of Blood Pressure After 1 month		After 6 Months		Favorable Effects on Chief Subjective Symptoms	Side Effects
				Systolic	Diastolic	Sys.	Diast.	Sys.	Diast.		
20-30	4	4 Gr. I	None	145 to 160	90	115 140	90 to 90	130	90	Excellent	Nasal stuffiness (1 case)
30-40	4	4 Gr. I	1 case	170	90 to 110	130 130	75 to 90	130	90	Excellent	None
40-50	17	14 Gr. I 2 Gr. III 1 Gr. IV	4 cases	150 to 210	90 to 130	125 180	90 to 120	120 210 1 case died	80 to 135	Good	Nasal stuffiness (1 case)
50-60	31	25 Gr. I 6 Gr. II	3 cases	150 to 230	90 to 140	100 190	70 to 110	125 195	80 to 110	Excellent	None
60-70	44	36 Gr. I 5 Gr. II 3 Gr. III	1 case	160 to 220	80 to 155	125 200	70 to 110	125 190	80	Excellent	Occasional Slight nausea
70-80	12	6 Gr. I 5 Gr. II 1 Gr. III	2 cases	170 to 220	70 to 120	120 200	70 to 120	140 185	85 to 100	Excellent	Nasal stuffiness (2 cases)
80-90	3	1 Gr. I 2 Gr. II	None	170 to 190	100	150 175	85 to 95	140 140	70 to 90	Good	None

8. Jeffers, W. A.: GP 10:66 (Sept.) 1954.

*Amounting to 2 cubic centimeters.

supplement the benefits provided by hydrogenated ergot alkaloids. Without the necessary rest and medication, however, these discussions would rarely have led to a sustained drop in blood pressure. All patients showed a definite relief of subjective symptoms unrelated to drop in blood pressure. Seven who required hospitalization have remained normotensive since their release from the hospital. Seven others require injection of the drug once or twice weekly, supplemented by one to two sublingual tablets three times daily in conjunction with a shorter rest period in the middle of the day. These patients maintain pressures of 130 to 150 systolic and 80 to 90 diastolic.

CONCLUSION

THIS is a preliminary report of 115 patients who received hydrogenated ergot alkaloids parenterally and sublingually over a period of 1 to 40 months in conjunction with psychotherapy, dietary and other measures for relief of hypertension of varying degrees. Evaluation of the various age groups indicates the importance of hypertension as a geriatric problem. Ninety of the patients fell within the 50 to 90 year age group. Sixty per cent of all cases treated showed left axis deviation and other electrocardiographic changes. In one-third of the patients with left axis deviation, previous electrocardiograms revealed that this abnormality was present for as long as 5 to 10 years before hypertension appeared. This suggests that when left axis deviation and other early electrocardiographic changes are present a patient should be periodically checked in an attempt to prevent hypertension.

The study stresses the importance of the patient-physician relationship and the necessity for adequate facilities for rest during therapy while in the physician's office. A drop in systolic blood pressure of 20, 30 or even 40 millimeters and in diastolic blood pressure of from 10 to 15 millimeters was not unusual following combined parenteral and sublingual administration of hydrogenated ergot alkaloids in conjunction with the other measures. Of even more value was the ability of the drug to promote a greater feeling of "well-being" and to provide definite relief of subjective symptoms such as headache, dizziness, and insomnia. All patients showed this definite relief of subjective symptoms unrelated to drop in blood pressure.

136 Broadway

Myosarcoma of the Stomach

Writing in the June 1955 Journal of the Oklahoma Medical Association, Rice states that bleeding is the most prominent symptom of leiomyosarcoma of the stomach. The bleeding occurs as melena or hematemesis. Pain is not a prominent symptom, and may yield to an ulcer regime. A slow-growing mass in the upper abdomen usually neither tender nor moving, is one of the earliest findings.

The roentgenogram reveals an extragastric filling defect, usually not involving the pylorus. Gastroscopy will demonstrate a mass protruding into the stomach. Biopsy may reveal a leiomyosarcoma. Differential diagnosis is important, as gastric carcinoma, lymphosarcoma, polypoid lesions, benign leiomyoma and sarcomas are the usual tumors resembling leiomyosarcomas.

Leiomyosarcoma of the stomach spreads slowly. The liver is a more common site of metastases, than the peritoneum. It occurs in 15 per cent of cases. Surgical intervention is the treatment; and surgical removal of the involved portion of the stomach even in the presence of metastases, offers hope of recovery. Roentgen rays, radium or nitrogen mustard do not alter the course of the disease.

W. A. Tansey, M.D.

Short Hills

Stevens-Johnson Disease

When constitutional symptoms, mucosal lesions, and an exudative erythema all arrive simultaneously in one body, the syndrome is called Stevens-Johnson's disease. Dr. Tansey reviews the literature and reports a case in which the patient responded with dramatic and gratifying suddenness to a new cortisone steroid known as "prednisone."

The earliest clear description of erythema exudativum multiforme was made by Hebra [1] in 1860. Erythema exudativum multiforme will be referred to in this paper as E.E.M. Six years later Hebra described a case of E.E.M. with pneumonia. About 40 years later, interest in this condition was revived, and several authors described E.E.M.† in association with buccal, vulvo-vaginal, penile and conjunctival lesions.

In 1922 Stevens and Johnson [2] first described erythema exudativum multiforme in association with severe constitutional symptoms, as well as with the previously noted mucosal lesions. Their name was then given to the syndrome. However, there has always been some confusion as to the exact definition of Stevens-Johnson's disease. Most authorities use the term, "Stevens-Johnson's syndrome," to designate E.E.M.† in association with mucosal lesions, including buccal, vulvo-vaginal or penile involvement. The addition to this clinical picture of pneumonitis would therefore infer a more severe stage of the same basic syndrome.

Kove [3] in 1945 for example, discussed two cases of Stevens-Johnson's syndrome which consisted of E.E.M.† plus mucosal involvements and fever and nothing else. One cleared spontaneously in one week, the other in three weeks.

When pneumonitis is associated with E.E.M.,† the prognosis is then guarded. Thus, in 1948 Finland [4] reported four cases in association with pneumonia, three of them fatal. The fourth suffered a stormy febrile course of eight weeks.

Ashby [5] in 1951 published a comprehensive review of this subject. He analyzed 77 previously reported cases of Stevens-Johnson's syndrome and added four of his own. All presented constitutional symptoms such as malaise, fever, sore throat, cough, and coryza. All had mouth lesions. Usually there was a gray or white membrane which, when pulled, left a bleeding ulcerated surface.

Seventy-four of Ashby's 81 patients had

†E.E.M. designates "erythema exudativum multiforme."

1. Hebra, F.: *On Diseases of the Skin, Including Exanthemata*, vol. 1, p. 285, London, 1866, The New Sydenham Society.

2. Stevens, A. M. and Johnson, F. C.: Am. J. Dis Child., 24:526 (1922).

3. Kove, S.: Am. J. M. Sc., 210:611 (1945).

4. Finland, M., Jolliffe, L. S. and Parker, F., Jr.: Am. J. Medicine, 4:473 (1948).

5. Ashby, D. W. and Lazar, T.: Lancet 1:1091 (1951).

conjunctivitis. Sixty-seven of the 81 had skin involvement. Most had genital lesions. Twenty-five of the 81 had parenchymatous lung lesions. Course of the latter cases was usually of three to four weeks' duration. Recurrence was reported in 18 cases. Eight of the 81 patients died; in seven of these the lung was involved.

Bradlow and Schless[6] give an excellent description of the skin lesion. These lesions are at first dark red oval macules varying from 5 to 20 millimeters in diameter. In a few days the macules become brownish purple papules, some of which acquire yellow, dry, necrotic centers. Later the lesions change to dark brown, horny, thick scales with raised paper-like edges. Then the scales drop off after the fourth week leaving faint pigmented areas.

Numerous attempts to determine the etiology have been charted in the literature.[7] Results have been inconclusive. Hypersensitivity to drugs,[5] psittacosis-like virus,[8] herpes simplex virus,[9] and many other etiologic hypotheses have been explored.

Below reported is a case of severe erythema exudativum multiforme which included pneumonitis, and which responded dramatically to prednisone. Prednisone is the delta analogue of cortisone and is, of course, a steroid.

On October 13, 1955, a 51-year old housewife was re-admitted to the Overlook Hospital in Summit. She had been a healthy woman and there was no prior history of asthma, hay fever, serum sickness, drug reactions, or serious infectious disease. In 1950 she had had a hysterectomy for fibroids. In the summer of 1952 she complained of "palpitations" and it was then that I first saw her. She had auricular fibrillation at the rate of 120 per minute. She had a plus 17 basal metabolic rate at that time. She was in euthyroid state from the fall of 1952 until October 1953. During that interval, the heart showed normal sinus rhythm.

In the summer of 1953, she took a clerical position. Since that time her thyroid gland has again caused trouble. She refused surgical and radiation correction of her thyrotoxicosis, so that it has been necessary to guide her with anti-thyroid drugs and periodic intervals of physical rest.

In October, 1953, she had a brief bout of rheumatoid arthritis. In December, 1954, she had erythema exudativum multiforme of all fingers. There was a possible relationship to chemical allergy since she had been employed for about a week prior to the onset of the eruption with chemicals, cleaning jewelry. Adequate skin sensitivity tests were not performed but patient responded promptly to cortisone.

Her first Overlook admission was in May 1955 for re-evaluation of her thyrotoxicosis. At this time her protein-bound-iodine was 10.2 micrograms per cent, basal metabolic rate was plus 7, and cholesterol was 144.

In September 1955, she had her second severe bout of rheumatoid arthritis. Following other unsuccessful therapy, she was placed on prednisone* and was promptly relieved. She had no further prednisone after September 27, 1955, until her present illness.

On October 10 she had developed an upper respiratory infection. By October 13 she had pneumonitis of the right lower lobe and was admitted to Overlook Hospital. There, temperature was 104, respirations 20. She had atrial fibrillation with a ventricular rate of 210 per minute. She was coughing considerably and non-productively. Her skin was pale, moist. There were purplish blotches on her fingers, at the site of the 1954 skin lesion.

Cervical nodes were moderately enlarged. Conjunctivae were normal. There was diminished resonance to percussion, diminished breath sounds and numerous rales over the entire lower half of the right posterior lung field and in the right axilla. Apical heart rate was 200 per minute. Sounds were of fair quality. No murmurs could be distinguished. Remainder of physical examination was non-revealing.

Chest x-ray confirmed the impression of pneumonitis at the right base and right midlung field. Urinalysis was negative. Red blood cells numbered 4,600,000. White blood count was 11,700 with polymorphonuclears 70 per cent, lymphocytes 27 per cent, monocytes 2, eosinophils 1. Hemoglobin was 11.7 Grams, color index 0.81. Sputum was negative for acid fast bacilli. Blood culture was negative. Electrocardiogram showed atrial fibrillation with ventricular rate of 210 per minute.

She was then re-digitalized. Propyl-thiouracil was continued at 50 milligrams three times a day.

Penicillin, tetracyclin and streptomycin were given on an overlapping schedule without benefit. Three days after admission, she developed a purplish red, maculo-papular rash over the forehead. By the next day, this eruption covered the entire body. Then an ulcer appeared inside of the lower lip. This enlarged to a half-centimeter diameter within the next 24 hours.

It was now realized that she had Stevens-Johnson's syndrome. All antibiotic medication was promptly discontinued. Prednisone,* 10 milligrams, three times a day, was started. The clinical response was dramatic. By that evening (October 17) her temperature was normal and she had a regular sinus rhythm at 70 per minute. Her cough almost en-

*This steroid—prednisone—is the delta analogue of cortisone.

6. Bradlow, P. A. and Schless, R. A.: J. Pediat., 32:293 (1948).

7. Womack, C. R. and Randall, C. C.: Am. J. Medicine, 15:633 (1953).

8. Urbach, E.: Zentrabl. f. Haut-u. Geschlechskr., 46:413 (1933).

9. Anderson, N. P.: Arch. Dermat. & Syph., 51:10 (1945).

tirely abated. The oxygen tent was removed on October 18. By October 23 all that remained was some purplish red blotching, scattered over the entire glabrous skin area. She was discharged to her home on October 23 on maintenance doses of prednisone,* Digoxin® (Burroughs-Welcome) and propyl-thiouracil.

SUMMARY

STEVENS-JOHNSON'S syndrome is the association with erythema exudativum multiforme of some mucosal lesions, whether buccal, vulvovaginal or penile, together with constitutional symptoms of varying severity, such as malaise, fever, sore throat, cough, coryza. When, in addition, pneumonitis is present, the outlook is grave.

A case of Stevens-Johnson's syndrome is presented which included pneumonitis. A dramatic response ensued upon cessation of antibiotics and institution of prednisone.*

85 Woodland Road

Fibrinogen in Obstetrics

Peterman[1] reported that the average normal plasma fibrinogen level of non-pregnant women is 260 mg./100 c.c. At term the level is normally 480 mg./100 c.c. When the placenta separates prematurely, thromboplastin enters the general circulation via the open sinusoids. Thromboplastin reacts with fibrinogen to form fibrin, which is deposited along the intima of the entire arterial tree. The fibrinogen level is drastically reduced, thus producing a clotting defect. Plasma fibrinogen is elevated in preeclampsia (ave. 510 mg./100 c.c.), in eclampsia (ave. 660 mg./100 c.c.) and in certain other conditions. The author observed a rheumatic patient with liver disease whose plasma fibrinogen level was 2200 mg./100 c.c.

Hodgkinson and his co-workers[2] find that the lower limit of normal fibrinogen plasma content is approximately 220 mg./100 c.c. Values approaching 150 mg. indicate subclinical defibrination. Clinical disease occurs when the plasma content falls below 150 mg./100 c.c. Critical defibrination requires prompt administration of fibrinogen. Whole blood is not especially effective in elevating fibrinogen blood levels; a 500 c.c. transfusion can be expected to raise the fibrinogen content of blood no more than 5 to 10 per cent. Recovery from defibrination normally occurs fairly rapidly but hemorrhage of incoagulable blood in untreated fibrinogen depression can be expected to continue from 2 to 4 hours following delivery.

Jackson *et al.*[3] *reports* on ten cases of fibrinogenopenia complicating pregnancy. He details the course of one patient who received fibrinogen. Six hours after admission and after the patient had received 1000 c.c. bank blood, plasma fibrinogen was 122 mg./100 c.c. Excessive bleeding occurred during cesarean section. After additional blood transfusion and administration of 1.05 Gm. fibrinogen, plasma fibrinogen was 144 mg./100 c.c. Fifteen hours postoperatively, plasma fibrinogen was 213 mg./100 c.c., increasing to 304 mg./100 c.c. on the fourth day following surgery. Recovery was rapid and uncomplicated.

Abruptio placentae with hypofibrinogenemia is the subject of a paper by Barczak.[4] He says that speed is essential in correcting fibrinogen deficiency in order to prevent irreversible changes in vital organs due to hemorrhage. Of 4 patients with hypofibrinogenemia following abruptio placentae, 2 died despite correction of the clotting defect by administration of fibrinogen. It is interesting to note that one patient who survived received 2.38 Gm. fibrinogen, which raised plasma fibrinogen from 61 to 210 mg./100 c.c. Theoretically, the level should have been elevated to only 149 mg./100 c.c.

In the same issue Gabriels[5] points out that premature separation of the placenta is not inevitably followed by hypofibrinogenemia. In a 67-bed obstetrical hospital, Gabriels[5] found records of 108 cases of abruptio placentae, but not one of these patients exhibited clinical evidence of any coagulation defect.

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1. Peterman, E. A.: Journal of the Michigan Medical Society, 54:308, March 1955.
2. Hodgkinson, C. P. *et al.*: Obstetrics and Gynecology, 5:465, April 1955.
3. Jackson, D. P. and others: Obstetrics and Gynecology, 5:223, January 1955.
4. Barczak, E. M.: Obstetrics and Gynecology, 5:248, January 1955.
5. Gabriels, A. G., Jr.: Obstetrics and Gynecology, 5:254, January 1955.

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Persistent Mental Aberration Associated With Trichinosis:

A Case Report*

Current thinking in psychiatry emphasizes the importance of chemical and other biologic factors in the psychoses, and de-emphasizes psychogenic factors. Here is a case in which trichinosis was associated with a subsequent schizophrenia. This was not apparently a schizophrenic-like reaction or a toxic psychosis simulating schizophrenia. This seems to have been a standard, classical schizophrenia.

The clinical manifestions of trichinosis are exceedingly variable. The widespread migration and deposition of the larvae on one hand and the hosts' immunologic response on the other, account for the protean characteristics of this disease. Involvement of the central nervous system has been reported on several occasions. Interest has centered for the most part on focal neurologic signs. Merritt and Rosenbaum[1] reviewed the case histories of 110 cases of trichinosis admitted to Boston City Hospital and found 19 had either absent reflexes, muscle weakness or stiffness of the neck. Patients with mild complaints recovered. However, the prognosis in patients presenting either signs of focal involvement of the brain or mental symptoms was likely to be grave; 6 of the 13 cases collected from the world's literature, according to Merritt and Rosenbaum[1] terminated fatally. This is a death rate of 43 per cent: considerably higher than the 5 per cent mortality rate usually cited[2] for the disease in general.

Barrett and Sears[3] reported a patient who had such personality and behavior changes that her family was convinced she was psychotic. A patient described by Stern and Daucy[4] developed an acute psychosis and had to be formally committed to a mental hospital. She died 19 days after onset of her symptoms. McCabe and Zatuchini[5] described another patient who was diagnosed, by a competent psychiatrist, as having an "acute schizophrenic reaction of the paranoid type." In many respects, this patient closely resembled

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1. Merritt, H. H. and Rosenbaum, M.: Journal of the American Medical Association, 106:1646 (1936)
2. Dammin, G. J.: "Trichinosis" chapter in *Principles of Internal Medicine*. Philadelphia 1950. Blakiston.
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the patient reported here. Recently a patient was admitted to Cooper Hospital in whom the outstanding feature of trichinosis was an acute schizoid state that persisted after the patient was otherwise clinically recovered.

A 22-year old woman had been well up until two weeks previous to her admission. She then noticed generalized aching pains which progressively became worse. In the next few days, cough, urinary frequency, and edema of the face appeared. Because of intensification of the backache, and the pains in the extremities, her family physician made a tentative diagnosis of poliomyelitis and sent her to a hospital for contagious diseases. There, the history of habitual ingestion of raw pork was obtained. Routine blood count revealed a 22 per cent eosinophilia. She was therefore transferred to the medical wards of the Cooper Hospital for the confirmation of the diagnosis of trichinosis and for therapy.

We found a well-nourished and fully developed, cooperative and well oriented woman. She was restless and uncomfortable. Her temperature was 102, her pulse was 106. Blood pressure was 100/55. Sclerae were reddened and the eyelids were markedly edematous. A few crepitant rales were heard over both bases. Except for the tachycardia, the heart was normal to physical examination. She had a profuse mucopurulent vaginal exudate.

On admission, the white count was 31,200 per cubic millimeter. Differential count was: 46 per cent polymorphonuclear leukocytes; 13 per cent lymphocytes; 41 per cent eosinophiles. The red blood count was 4,600,000 cells per cubic millimeter. Hemoglobin was 13.7 Grams per cent. Sedimentation rate was 10 millimeters per hour (Cutler). Urinalysis was negative, except for a faint trace of albumin. Blood and urine cultures were negative. Stool was negative for ova and parasites. Fasting blood sugar was 74 milligrams per cent. Plasma albumen was 2.9 Grams per cent with a globulin of 2.3 Grams per cent. Spinal fluid was microscopically and chemically normal. The precipitation test for trichinosis was positive in a dilution of 1 to 1600.

Electrocardiogram shortly after admission showed evidence of myocardial damage. A tracing repeated later showed much less deviation from normal.

On the twenty-ninth hospital day a biopsy of the gastrocnemius muscle was taken. Sections of tissue from the muscle revealed marked swelling and edema, with encystation of trichini in the muscle, and varying degrees of cellular reaction. The cellular reaction was composed of polymorphonuclear, mononuclear cells, plasma cells and, in some areas, a marked giant cell formation. Microscopic appearance was typical of trichinosis in an exceptionally early stage. See the figure.

Five days after admission the patient abruptly became psychotic. She manifested auditory and visual hallucination, increased psychomotor activity, confusion, disorientation and ideas of reference. She became combative and refused medication on the delusional basis that the attending personnel were experimenting upon her. At this time, examination revealed some nuchal rigidity, suggestive facial diplegia and absent tendon reflexes. Eye grounds showed several small retinal hemorrhages. She gradually became more manageable. However, even at discharge seven weeks later, the patient refused to believe she had been ill. She developed unusual religiosity and said she felt "strange sensations" throughout her body when she touched or read the Bible. She still had ideas of reference. It was the opinion of the consulting psychiatrist that she still manifested a schizoid reaction of paranoid type.



Biopsy gastrocnemius muscle. See text for discussion.

Interview of her parents, other relatives and her clergyman revealed that she had always been considered well adjusted. It was the opinion, one year later, of a close relative that the patient had never recovered her usual emotional status. She had become seclusive, and increasingly over-religious. Whereas, before the illness she had a wide spectrum of social and recreational interests, all these had shrunken, and religion was now her major, indeed almost her only, focus of life interest.

Despite the widespread dissemination of trichini during the course of the illness, which would lead to cerebral involvement, neurologic and psychiatric aspects of the illness have not been reported frequently. When psychiatric or neurologic symptoms do occur, several explanations are offered: (1) psychotic manifestations are merely secondary to the non-

specific toxic effects of the disease, (2) there is presumed to be a trichinous-encephalitis or meningo-encephalitis; or (3) cerebro-vascular changes secondary to embolic phenomena from a primary trichinous endocarditis. Pathologic studies substantiate the latter two conditions. Clinical experience with other infectious disease processes justifies the first possibility.

Several kinds of pathologic changes have been described in cerebral trichinosis. These range from nonspecific alterations as edema, congestion, and infiltration [6,7] to specific nodule formation with trichini.[8,9] Scattered punctate hemorrhages have been reported in the cortex, as well as the medullary portions of the cerebrum.[10] Embolic lesions also from parasitic endocarditis have been reported in other studies.[11]

In this patient (as in others who have survived) the exact pathologic process is uncertain. But some of the associated clinical findings are suggestive.

It is doubtful that the acute mental manifestations due to a nonspecific toxicity would persist for a protracted period after the cause was removed; *i.e.*, recovery from the acute phase of trichinosis. Therefore, other explanations for these mental changes must be sought. It is impossible to differentiate between trichinous embolization and encephalitis, except that in the former, one would naturally expect more focal signs than we found in this patient. Other cases [5,11,12] having a similar clinical picture have been reported. One showed, at postmortem, both a trichinous myocarditis and encephalitis.

Persistence of neurologic findings following trichinosis has been documented in the literature in a few instances. Nystagmus and deafness,[6,12,13] have been reported as persisting long after the patient was otherwise clinically recovered. Moreover, convulsive states, according to Dandy,[14] may be a sequella of trichinotic encephalitis. Widespread neurologic changes were also found in a case cited by Bleir.[17] He attributed muscular atrophy, paresis and patchy areas of anesthesia to trichinosis infection. The patient died of his illness one year after the onset in a cachetic state without neurologically recovering.

In the case reported here, it may be that the trichinous encephalitis merely uncovered a latent schizoid tendency. This cannot be easily refuted. However, it is well known [16] that chronic mental changes may persist after other types of encephalitides. Therefore, brain damage must be seriously considered as an etiologic factor.

SUMMARY

A CASE of trichinosis is described in which the outstanding clinical symptom was a schizophrenic reaction that persisted beyond the acute disease state.

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573 Stevens Street

Paul L. Reilly, M.D.*

Montclair

Osteogenesis Imperfecta Tarda and Hyperhidrosis

Dr. Reilly reminds us that a history of repeated fractures should make the doctor think of osteogenesis imperfecta. In this case, the hyperhidrosis was an unusual and confusing feature.

Osteogenesis imperfecta tarda, an uncommon disease, has previously been reported in relation to hyperuricemia and gout, psychosis, and various problems related to pregnancy. Review of the literature fails to reveal its association with hyperhidrosis. The possibility of a relationship will be discussed.

A 21-year old woman came to the clinic because of acute hyperhidrosis of the tips of the fingers and secondary infection of the right thumb and index finger. This was of four days' duration and had been preceded by an "acute emotional upset." The patient's scleras were a grayish-blue and the skull abnormal in contour. Her history included several previous fractures. A maternal aunt and grandparent, the mother, a sister 19 years of age, and a brother 15 years of age all had blue scleras and frequent broken bones. The remaining four children, all boys, had white scleras and no fractures. The mother has had six separate fractures in her lifetime. The patient's 19-year old sister had fractured three bones, all after the onset of puberty. The younger brother has fractured four or five bones.

The patient fractured her right femur at 17 months and right ankle at two years of age. At 9 years she broke her right third finger catching a ball and a short time later fractured the left elbow upon falling. In April, 1955, she broke the right ring finger catching a baseball.

The pertinent personal history is limited to the mumps at 10 years of age. She has had a minor defect in hearing ability since which is mildly progressive. There was a questionable mastoiditis at that time.

The positive physical findings were limited to the marked increase of the bitemporal diameter and occipital protuberance giving the head a triangular appearance. There was bilateral decrease in the tympanic membrane light reflex with some scarring on the right. Neither tympanic membrane was blue. There was a mottled, reddish-purple hue to the tips of all fingers, each being covered with beads of sweat. However, the fingers were normal in temperature and pulsations. Secondary infection of the thumb and index finger had occurred.

Hemoglobin, 12.4; R.B.C., 4.26; W.B.C., 14,000, 67 P, 27 L, 6 M; hematocrit, 40; sedimentation rate 19 mms. corrected; B.M.R., plus 23; radioactive iodine uptake, 32 per cent; serum calcium, 10.35; cholesterol, 210; phosphorus, 3; alkaline phosphatase, 2.7.

X-rays of the skull showed typical changes of the disease, with increase in the bitemporal and antero-posterior diameters. The long bones showed excessive tubulation of the shafts with flaring of the ends, but no specific thinning of the cortex.

The infection of the fingers was treated with local therapy, incision and drainage, and rapidly cleared. The hyperhidrosis responded to methantheline.‡ Three weeks after the initial interview the patient underwent emergency appendectomy. She is now recuperating nicely.

Osteogensis imperfecta has been divided into the congenital and late form, which is now known as *tarda*. It was felt by some that these represented two distinct entities. However, Kellogg[1] described a family in which both types occurred. The disease follows a dominant pattern, approximately one-half of a generation being affected.

Characteristically, the patients have numer-

*Dr. Reilly is the Chief Resident at the Mountainside Hospital in Montclair.

‡Tradenamed as "Banthine" (Searle). The dose was 50 milligrams, three times a day.

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ous fractures occurring after infancy and diminishing in frequency after 20 to 30 years of age. At this age, 60 per cent develop otosclerosis, which is progressive. Laxity of ligaments, with alterations in bone and blood vessels have been described. In Kellogg's series,[1] 72 per cent had exophthalmos; however, no mention is made of basal metabolic rates. Others have occasionally reported elevated metabolic rates, but no further statement is made of thyroid disease. Blue scleras with the bony changes described in this patient are typical.[2]

THIS patient fulfilled the requirements for osteogenesis imperfecta tarda; however, she did not have exophthalmos, blue tympanic membranes, nor brown discoloration of her teeth.

Cause of the disease is unknown. Rosenbaum[3] felt that he had some success in preventing fractures with anterior pituitary extract, but his studies have not been confirmed by others. The relationship of the thyroid is inferred by the high reported incidence of exophthalmos and in some instances, elevated metabolic rates. Our patient showed the elevated metabolic rate but a normal radio-active iodine uptake. The patient's sister, who also has the disease, is being treated in another clinic for hypothyroidism.

Key[4] feels the disease to be due to a hereditary hypoplasia of the mesenchyme. Although accepted by most, this does not explain the occasional occurrence of ectodermal involvement, specifically teeth and nails.[5]

The suddenness of onset of the acute hyperhidrosis may be explained on the basis of psychic trauma. In this case, the trauma was a severe argument with the employer. However, one wonders what part a labile blood vessel system may play in the hyperhidrosis and what its association may be, if any, with osteogenesis imperfecta tarda.

This case is being reported because of the associated hyperhidrosis and also to remind the practitioner that the disease may be easily overlooked, and should be suspected in anyone found to have frequent broken bones.

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The Mountainside Hospital

Urine Output in Pregnancy

Writing in the 1955 Am. Journ. Obstetrics & Gynecology (69:1225), Hendricks and Barnes say that, in pregnancy, urinary excretion during the last trimester was considerably greater when patients were lying on their sides than when they were lying on their backs. The difference in urinary excretion is related to mechanical obstruction at or below the kidney brim. When patients remain in the supine position for extended periods (up to 16 hours), there is eventually a "breakthrough" which brings the output in the back position within the range of that in the side position. At the "breakthrough" point the pressure within the renal pelvis probably rises above that which blocks the ureter.

Pritchard, *et al.*, (J. Clin. Invest. 34:777, 1955) state that renal response to the supine position is not peculiar to pregnancy. Similar changes are observed in women with large abdominal neoplasms. In such cases, reduced urinary excretion is probably due to venous compression rather than ureteral obstruction.

Arthur Krosnick, M.D.
Trenton

The Responsibilities of the Patient, Physician, and Community in Long Term Diabetes Control*

In this brief article, Dr. Krosnick compactly spells out the responsibilities of the patient, the physician and the community in the control of one of our important diseases.

Diabetes mellitus has fascinated and frustrated physicians since the time of the ancient Greeks. It has replaced syphilis as "the great imitator"—for the afflicted individual may first present himself to the ophthalmologist, dermatologist, gynecologist, or any other practitioner of general or specialized medicine, with a symptom of uncontrolled diabetes. Like syphilis, the diagnosis ultimately depends on a laboratory procedure and, all too frequently, the undiscovered or inadequately treated diabetic may make an appearance with irreparable ocular, vascular or central nervous system damage, as his syphilitic confrere of previous generations did.

Mass screening for syphilis has been with us for some time now, but screening for diabetes is in its puberty, a difficult and formulative period.[15] The professionals in the field of screening examinations sometimes falter. Is it worth all this effort? Should I use blood or urine? Do I really do any good by the early discovery of diabetes? The prospective participants hesitate to be "screened." Hand 100,000 Dreypaks to potential diabetics, as we did in New Jersey in 1954, and get 15 per cent back![8] Many people just don't want to be discovered! Consider the 32-year old housewife, mother of two children with 10 years of untreated diabetes, retinopathy, chronic pyelonephritis, and gallstones, who refuses to take insulin despite the fact that she is underweight and has never had a blood sugar below 175. Why did Doctors Banting and Best bother to discover insulin, anyway?

The answers to the frustrations I have cited rest on two virtuous qualities; patience and education. We need patience because people (including physicians) are not always ready to learn—even though they are exposed to something we think they should know. We need patience because the complete answers to the mystery of diabetes and its altered physiology are still forthcoming. In the meantime, we have more than enough to keep us and our patients busy—we have many types of insulin, diet, antibiotics, vitamins and many other adjuvants in the care of the diabetic. Most of all, we have knowledge to impart to the one who needs it. The diabetic patient is the master of his own fate and his physician, important though he be, is merely the rudder.

All programs of diabetes control have common factors: case-finding, patient education, public education, professional education, and research. Each entails responsibility. Ultimate

*Presented at the Third Annual New Jersey Diabetes Association Symposium on Diabetes Mellitus, October 26, 1955. Dr. Krosnick is Coordinator, Diabetes Control Program, Division of Chronic Illness Control, New Jersey State Department of Health.

aim of the combination is long term control of diabetes on an individual, as well as a state and national basis.

RESPONSIBILITIES OF THE PATIENT

THE diabetic has the most important and most difficult of the responsibilities of long term control. He must first accept the diagnosis of diabetes and be willing to assimilate the fact that he has a chronic disorder which makes him different from the non-diabetics of the world. The "recalcitrant" diabetic is often the highly sensitive, emotionally disturbed individual who cannot psychologically accept such a diagnosis. The patient must be willing to undergo regular medical supervision and must carry out his own treatment from day to day. This differs from acute medical conditions, but it is a modality common to certain other chronic disorders, such as pernicious anemia, hypertension and epilepsy.

The diabetic should learn the early symptoms of hypoglycemia. Impending acidosis should be recognized promptly. The careful management of the diet, insulin, syringe care, and urine testing should become part of his life. He should know how to handle himself when acute problems, such as upper respiratory infections and digestive upsets, appear. By all means, the patient should swiftly communicate with his physician about such problems—in order to avoid diabetic acidosis, which is frequently preventable. The diabetic should have an insatiable curiosity about his condition—and ask questions! He should read one of the standard patient manuals, attend diabetes classes and read the American Diabetes Association *Forecast*. General body hygiene and proper care of the feet are the vital responsibilities of the patient.

The diabetic should encourage his blood relatives to have screening tests for diabetes periodically. He should know the hazards of marrying another diabetic. This offers potential difficulties because love has a way of developing before the participants are aware of each other's postprandial blood sugar level. He should not become obese—or should reduce if he is overweight.

Meeting these responsibilities helps control the diabetes and delay or prevent complications and secondary disabilities.

RESPONSIBILITIES OF THE PHYSICIAN

THE physician who accepts a diabetic patient is taking a potentially heavy weight on his shoulders. This may prove disheartening or rewarding. Diabetics are usually very nice people who are grateful and loyal. I do not know what percentage of the known million diabetics in the United States are under the care of family physicians or "diabetes specialists." One panelist at a recent meeting described a "diabetes specialist" as a physician who is willing to sit down with his diabetic patient and talk with him about his disease. The general practitioners, who see the great mass of people each day, are the best screening method known. If each practitioner in New Jersey tested three patients in his office during Diabetes Detection Week alone, we will have screened more people than our whole Statewide drive of 1954 did—with far less expense and effort. The practicing physician is the keystone in diabetes detection and should help discover the unsuspected cases at the earliest possible moment. When a participant has glycosuria or borderline hyperglycemia, he must not be willing to accept it as unimportant, but should pursue the matter to a conclusion, by acceptable methods of followup. When Wilkerson and his associates[16] returned to their New England town four years after the original epidemiologic survey, they re-evaluated the individuals originally placed in a "blood sugar suspect group"—you might say these individuals had a "touch of sugar." They had borderline blood sugar levels, but did not fulfill the criteria of diabetes. Re-examination four years later disclosed that 14 per cent of them were frank diabetics while fewer than 2 per cent of a control group had the disease. Physicians are too often willing to pass off urinary sugar in a pregnant female as a natural phenomenon without obtaining a blood

sugar. In the follow-up of the 1954 Diabetes Detection Drive, one New Jersey physician indignantly informed us that the glycosuria found in one of his young patients was unimportant because the person had eaten a lot of candy prior to voiding the specimen and no blood sugar determination was necessary. It seems to me that the "touch of sugar" is a diagnosis which is entitled to a "touch of follow-up" and often requires a "touch of treatment" as well.

IT APPEARS grossly to the neophyte in diabetes management that modern medicine has a double, or perhaps a triple, standard of diabetes control depending on whether one comes from Boston, New York or somewhere west of these two cities.[4,5,6,13,17] The advocates of "chemical control" of diabetes seek to attain normal blood sugar levels and sugar-free urine by weighed diets and multiple doses of insulin if necessary. Those who seek "clinical control" of diabetes aim to maintain the patient symptom-free, acetone-free and normal in weight. The level of blood and urine sugar are said not to be important. The intermediate groups try for "chemical control," but are less compulsive about their demands, where the ideal cannot be practically attained. The first two schools are not as far apart as they appear, since the diabetic can hardly be symptom-free, acetone-free and maintain body weight and still have a high blood sugar and glycosuria. All agree that acidosis and hypoglycemia should be avoided.

Whatever the plan, the physician must decide his standard of control and stick to it. He cannot be vague and uncertain in his instructions to the patient because the attitude of the physician will quickly be adopted by the patient.

Objectives of control, by any method, are freedom from symptoms, maintenance of adequate growth and nutrition, protection of the insulin-producing capacity of the pancreas, continuation of the diabetic as a useful, functioning member of society, maintenance of the female capability for procreation of living and healthy offspring, and the prevention of complications. The latter includes the prevention of short-term problems such as acidosis and hypoglycemia. Prevention of secondary disabilities, on a long term basis, includes the "diabetic triopathy" (retinopathy, neuropathy and nephropathy) as well as accelerated vascular sclerosis and gangrene.

Long term control of diabetes depends on diet, insulin, balanced activity and thorough education of the patient. The periodic check-up by the physician should include an evaluation of diet, urine tests, insulin reactions and interim interpretation and instructions concerning the disorder. A blood sugar determination, complete urinalysis, record of the weight and examination of the feet are a part of each examination. The diabetic should have an annual chest x-ray and complete physical examination.[4]

Medical social workers, public health nurses, and nutritionists can provide invaluable assistance to the physician in the total care of the diabetic. Another essential feature of the physician's responsibilities is psychological assistance. The physician can help the patient maintain an emotional balance in an essentially non-diabetic society. The diabetic has a unique chronic illness, as well as all the medical, social and psychological problems of his non-diabetic neighbors. He usually has an added economic burden, by virtue of the need for insulin, needles, syringes, urine-testing materials and the fee of periodic medical and laboratory examination. Emotional tranquility is an essential requirement for the diabetic to maintain satisfactory long-term control.[7]

RESPONSIBILITIES OF THE COMMUNITY

ALONG with the patient and the physician, the community holds the third corner of the triangle of responsibility in long-term diabetes control. The "community" includes all groups of individuals, agencies and associations, essential for the implementation of any public health program. Case-finding and public and patient education programs are not possible without the active participation of the community, including organized medical groups,

official public health agencies, voluntary community organizations and hospitals. The New Jersey Diabetes Detection Drive is sponsored by The Medical Society of New Jersey and each of its 21 county societies, the New Jersey Diabetes Association, and the New Jersey State Department of Health.[8] Participating community organizations include the chapters of the American Red Cross, New Jersey Congress of Parents and Teachers, New Jersey Health Officers Association, New Jersey Hospital Association, New Jersey Pharmaceutical Association, New Jersey Society of Clinical Pathologists, the professional nurses organizations, the Woman's Auxiliary to the Medical Society and others, including County Tuberculosis and Health Associations. A drive of this magnitude can succeed only if it enjoys assistance at all levels of participation.

Public education implies an orientation of citizens to the problem. Mass health education is like leading the horse to water. The general public must be willing to be educated. Public attitudes are more frequently based on the fear of dire consequences related to dreaded complications than they are on the rewards and virtues of good health practices. Our process of public education in relation to diabetes must necessarily be an attempt at a balance between these forces.

DIABETES is a major problem in New Jersey! It ranked sixth as a principal cause of death in this state for all age groups in 1954. Of the total deaths, 2.2 per cent (or 1106 deaths) were attributed to diabetes.[11] The true figure is probably higher since diabetes is often omitted from the death certificates in patients whose deaths are attributed to "Diseases of the Circulatory System" or other major causes of death.

In a New York City analysis in 1954, only 37 per cent of known deaths among diabetics were ascribed to the disease. A Metropolitan Life Insurance Company study in 1954 indicated that 60 per cent of deaths among diabetics were recorded as due to diabetes. In general, the total mortality of diabetics and the frequency of diabetes as an associated or contributory cause of death are under-reported on death certificates. Over 80 per cent of diabetics die from arteriosclerosis, particularly heart disease and cerebral accidents.[9]

A recent study of the foot complications of diabetic patients was conducted in seven Boston hospitals.[2] During one year, 502 patients stayed an average of 30 days in the hospital for surgical consultation or treatment. Major amputations were done in 90 patients. These individuals had an average of 27 days of outpatient treatment prior to hospitalization. Reflect upon the total cost in days and dollars for this one type of complication!

The diabetic must not be denied equal opportunity to be productive and self-supporting because of his underlying disease; nor should he have to hide his diabetes to gain employment. In some industries, glycosuria on a preemployment examination, automatically excludes the person from employment. Others, however, regard diabetics as normal employees as long as they maintain reasonable control under the supervision of a physician.

THE Committee on Employment of the American Diabetes Association has been investigating this problem.[3] They have formulated standards for the employment of diabetics based on the philosophy that controlled diabetics are good employable risks. Certain concessions are obvious. Work hours should be steady; the midnight to 8:00 a.m. shift should be avoided. Diabetics who are taking large doses of insulin should not be assigned to work in which hypoglycemic attacks might result in injury to themselves or others. A scaffold, therefore, is not a good location for such an individual.

There are many positions the diabetic can and should be allowed to fill—depending on his own capabilities.[10] In general, the well-controlled diabetic, who is compulsive and conscientious about his diet, insulin and body hygiene, is likely to transfer these characteristics to his work as well and prove to be an unusually capable employee.

This problem naturally fuses with that of insurance—life insurance, hospital and accident insurance, workmen's compensation and

the like. Since 1940, life insurance policies have become more readily available at cheaper rates to the diabetic.[5] Criteria for rejection have primarily been based on the presence of complications such as cardiovascular and renal disease. In general, compensation laws protect the diabetic as well as the non-diabetic.

The community should provide adequate clinical and hospital facilities for the diabetic population. A recent survey indicated 51 New Jersey hospitals which maintain a special clinic for diabetics or provide specific out-patient care for diabetic patients in their general medical clinics.[1] Such clinics are excellent hubs from which to radiate patient and public education, to do case-finding through relatives of known diabetics and to do clinical research concerning the many unanswered questions in this interesting disorder of metabolism.

SUMMARY

DIABETES is a medical, public health and socio-economic problem which demands a co-operative approach for total management. The patient, the physician, and the community have important responsibilities to fulfill in any diabetes control program.

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Clinical Research Federation

Interested in clinical investigation? If so, you will be pleased to know that a New Jersey branch of the American Federation for Clinical Research has just been chartered. For details write to the secretary, Dr. Milton Shoshkes, 505 Elizabeth Avenue, Newark 8, N. J.

R. J. Ryan, M.D.

Solomon Weintraub, M.D.

Trenton

Acute Hepatic Necrosis*

One of the hazards of blood transfusion is underlined by this case report of acute hepatic necrosis and "ammonia intoxication." The case was complicated by an intercapillary nephrosclerosis.

Since World War II, our knowledge of viral hepatitis and its sequelae has rapidly expanded. We have progressed from realization that viral hepatitis is not an obstructive phenomenon of the common bile duct. We now understand the need to study its histogensis "in three dimensions," as Popper and Elias [1] put it.

Although extensive acute hepatic necrosis is a rare result of viral hepatitis, it is something which always has to be kept in mind. The degree of jaundice is not proportionate to extent of hepatic destruction. Jaundice appears to be due chiefly to occlusion of bile canaliculi by plugs of bile.

In the genesis of the liver's collapse following necrosis, due to viral or toxic agents, Popper and Elias [1] have demonstrated maintenance of the liver's reticulum framework for a time followed by collapse and development of collagenous fibers. The process incites portal and periportal inflammation.

In fatal cases of short clinical course, the liver is usually reduced in size, soft and dark reddish-brown in color.[2] If the course is longer the liver becomes very small and wrinkled.

Blood transfusions have been blamed for serum hepatitis. In one recently reported case [3] infectious hepatitis (usually spread by the fecal-oral route) was apparently transmitted by transfusion of infectious blood taken from a patient in the viremic stage of infectious hepatitis. In such a case, human serum gamma globulin might have been helpful.

Much clinical work has recently been directed toward the roles of ammonia and L-glutamic acid in hepatic coma. Disturbances in ammonia metabolism were shown to be related to neurologic changes and reversible electrocardiographic states. The alterations in ammonia levels were related to intrahepatic disease or a portocaval shunt or a combination of both. In man, the most important source of ammonia is the intestinal tract. The liver normally converts ammonia to urea. Blood in the gastro-intestinal tract, a high protein diet and excessive ammonium chloride are some causes of exogenous toxicity. Endogenous intoxication may occur with acute hepatic failure.[4] The normal ammonia level [5] in serum is 50

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*From the St. Francis Hospital, Trenton, New Jersey.

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micrograms per cent. Muscle may take up excessive ammonia in arterial blood. We must not, however, consider disturbed ammonia metabolism as the only facet of a decompensated liver which is involved in a myriad of protein, carbohydrate and fat processes.

Krebs[6] in 1935 showed that brain slices could synthesize glutamine from glutamic acid and ammonia in the presence of glucose. This was supposed to account for glutamic acid to bind the toxic excessive ammonia. Using 25 Grams per day of L-glutamic acid or its salt, proved successful in acute exogenous coma and chronic liver diseases with encephalopathies. The spontaneous comas with liver collapse showed only transient response.

CASE REPORT

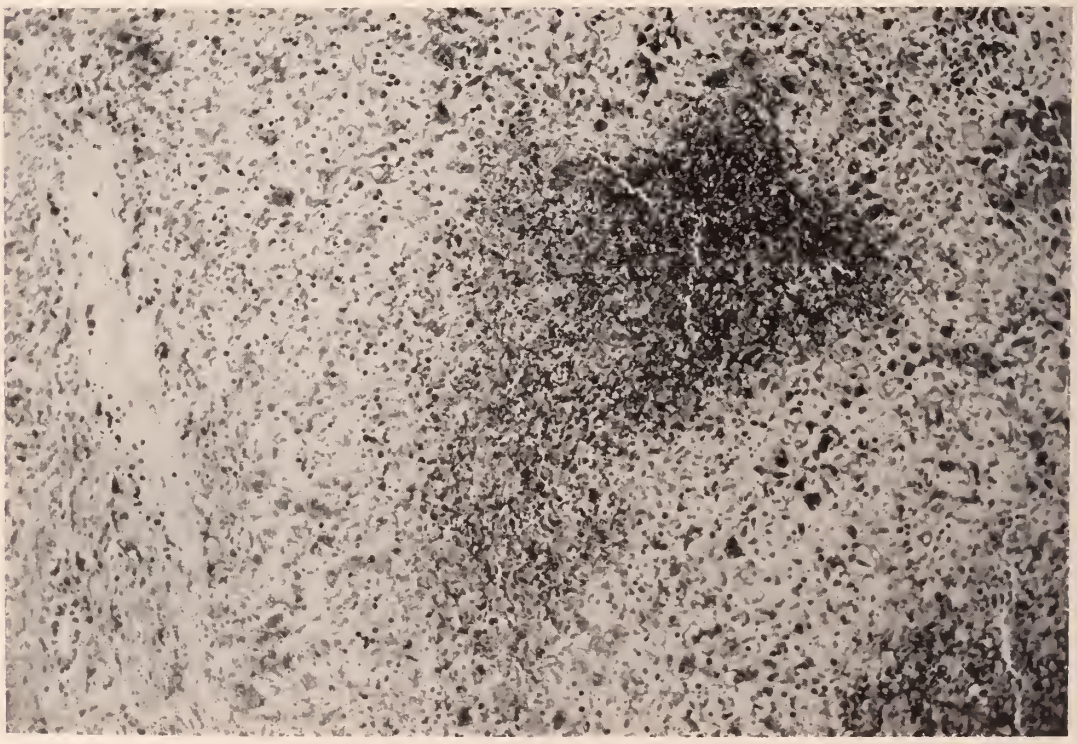
A 58-year old female was known to have diabetes and hypertensive cardiovascular disease. She had had albuminuria in the past and retinal changes. She had received 1000 cubic centimeters of whole blood during a previous hospitalization. She had received in the week before the present readmission three injections of chlorpromazine for vomiting. She was re-admitted 66 days after the last blood transfusion. On re-admission, she complained of cough and dizziness. On the day of admission she became clinically icteric.

She was a jaundiced well developed woman with a blood pressure of 180/100 and temperature of 99 degrees. There were no spider angiomata. A loud systolic murmur was heard in the left sternal area. Lung examination revealed no rhonchi. The liver was palpable with deep inspiration just below right costal margin. Blood sugar on the day of admission was 536 milligrams. The blood urea nitrogen was 100. Carbon dioxide was 31½ volumes per cent. White cell count was 11,000. Next day the blood urea nitrogen was 60 and creatinine was 3.16. Thymol turbidity was 23.2 units. Cephalin flocculation was 4-plus. A few hours later blood urea nitrogen dropped to 17. Bilirubin then was 11.3 with icteric index of 100 units. Prothrombin time was 37 seconds. The A/G ratio was 3.1/2.7.

On the third day she became lethargic. She expired at midnight.

At autopsy, a soft liver with focal red areas was found. It had not shrunken appreciably. The liver weighed 1200 Grams. Microscopically the liver revealed lobular necrosis with inflammatory cellular infiltration. The figure shows these findings.

6. Krebs, Adolphus, cited by McDermott.[4]



Acute Hepatic Necrosis

Also found was typical capillary glomerulosclerosis of the kidneys. This is characteristic of Kimmelstiel-Wilson's disease.

This case is interpreted as serum hepatitis followed by hepatic collapse. We do not believe that chlorpromazine (Thorazine®) played any part in causing this disease because of the course, the liver function tests [7] and the histopathology.

We are indebted to Dr. Edwin Gilbert of the Pathology Division of the Department of Health Laboratory of the State of New Jersey for the excellent micro-photograph.

7. Sussman, R. M. and Sumner, P.: New England Journal of Medicine, 253:499. (1955)

601 Hamilton Avenue

The One-Eyed Worker is Safe

Employees who have permanently lost the vision of one eye are less handicapped than normal two-eyed individuals who temporarily have the vision of one eye obscured, according to Dr. Christopher Leggo of Menlo Park California. Rather, Dr. Leggo notes, most persons who have permanently lost the sight of one eye have compensated for the lack of binocular vision with impressive adroitness. This appears in the November 1955 *Industrial Medicine*. Although depth perception requires binocular vision, "Many ophthalmologists confirm the fact that with long practice the one-eyed individual seems to develop depth perception to a highly satisfactory degree and can perform very well when tested for this ability." Dr. Leggo says: "I am unable to recall any of the many one-eyed employees I have seen who were oustandingly misfit. On the contrary, I believe that their performance is above average."

The Vegetarian Fanatic

During the last century, thousands of vegetarians refrained from eating meat although still consuming animal products like milk and cheese. During the last ten years several hundred food-faddists have decided to eliminate all forms of animal products from their diets altogether.

This study* concerns the clinical picture presented by some of these *vegans,* as they term themselves, after several uninterrupted years on diets entirely devoid of animal proteins. A total of 151 subjects were involved in this study.

The commonest and earliest symptoms have been in the mouth with sore tongues being especially common. These oral symptoms usually cleared after a month even when the diet was maintained.

Amenorrhea and menstrual disturbances were encountered in eight out of 22 women in the 15 to 45 year age range. About 20 per cent of the subjects complained of back pain. Twenty per cent also complained of paresthesias.

These symptoms suggested vitamin B_{12} deficiencies which, in fact, proved to be the case when serum concentrations were determined. Vegan serum vitamin B_{12} levels ranged from 45 to 193 uug./ml. and averages 111 uug./ml. as compared to a normal range of 200 to 320 uug./ml.

Although some of the subjects showed a slight anemia, none showed a hematologic picture characteristic of pernicious anemia.

*Wakes, F., Badenoch, J., and Sinclair, H. American Journal of Clinical Nutrition, 3:375 (October) 1955.

Seymour L. Hanfling, M.D.

East Orange

Chloroquine in Chronic Discoid Lupus Erythematosus

Chloroquine proved gratifyingly effective in clearing several cases of chronic discoid lupus erythmatosus according to Dr. Hanfling's reports.

The rapid, spectacular, and uncomplicated response of five of my last six cases of chronic discoid lupus erythematosus has prompted me to publish these results.

Prior to 1950, chronic discoid lupus erythematosus presented a major therapeutic problem. Treatment could well be compared to that of syphilis before the use of penicillin; being painful, prolonged, and frequently toxic. Following the war, quinacrine (Atabrine®) was found to be a relatively effective medication for chronic discoid lupus erythematosus as evidenced by the large number of reports published in the late 40's and early 50's.[1-3] This drug, however, resulted in an undesirable skin discoloration in all and blood dyscrasias[4] in some patients treated, not to mention the headaches and gastric upsets.

The results obtained from quinacrine therapy stimulated further investigation into the use of other anti-malarials. Soon we had chloroquine (Aralen®) which is the drug used by my six patients. I have never before had five consecutive cases of chronic discoid lupus erythematosus respond so well and so rapidly to any one drug or group of drugs. The sixth and worst case improved but still shows activity and infiltration of the lesion on his face. For details of location, dose and results, see the table.

The importance of this advance in therapy cannot be overestimated. Previous treatment with liver or bismuth over long periods resulted in many sore gluteal muscles or even in attacks of sciatica. Intravenous arsenic or gold was equally uncomfortable, and carried the constant danger of severe toxic reactions. Results were erratic.

We now have a means of treating these cases with a relatively non-toxic oral medication which requires a few check-ups early in treatment and then can be followed monthly and later every two months. These latter visits are to renew the prescriptions, to re-examine the urine and to repeat the blood count. Every patient who has been through the old courses of therapy welcomes the ease of treatment and the excellence of results with great enthusiasm.

1. Cole, H. N., Jr., Chivington, P. V., Jr., Cole, H. N. and Driver, J. R., Jr.: J.A.M.A. 153:1515 (December 26) 1953

2. Zakon, S. J. and Gershenson, J.: A. M. A. Arch Dermat. 71:520 (April) 1955

3. Wells, G. C.: J. Invest. Dermat. 19:405 (December) 1952

4. Palmer, L. G. and Sawitsky, A.: J.A.M.A. 153:1172 (November 28) 1953

SUMMARY

1. Chloroquine (Aralen®) in 240 milligram doses, has given me complete clearing of chronic discoid lupus erythematosus in four

cases, practically complete clearing in a fifth severe case, and patient satisfaction but persistence of the eruption in the sixth and most severe case. The dose is indicated in the table.

2. Three have remained clear for five to seven months without therapy.

3. One is clear after a year on half the therapeutic dose.

4. One patient developed a dermatitis medicamentosa reproduced by ingestion of the drug. No blood dyscrasia, urinary changes or other side reactions occurred.

EFFECTS OF CHLORAQUINE ON CHRONIC DISCOID LUPUS ERYTHEMATOSUS

Age, Sex and Color	46-F-W	47-F-W	60-F-W	60-M-W	41-F-W	49-M-C
Duration	4 years	10 years	3 years	1 year	5 years	6 years
Site	Face, arms, neck	Face, scalp, neck	Face	Ears, chest, face and shoulders	Lobe of right ear	Cheeks, upper lip and hairline
Previous Therapy	Hydrocortisone; liver; Atabrine®; bismuth*	Bismuth (helped 10 years ago)	Hydrocortisone* orally	None	Hydrocortisone* ointment	Penicillin*
Dose of Chloraquine	240 milligrams b.i.d.	240 mg. b.i.d.	240 mg. b.i.d.	240 mg. b.i.d.	240 mg. b.i.d.	240 mg. b.i.d.
Weeks before Eruption Cleared	8	16	8	16†	12	10†
Untoward Effects	Vertigo. This symptom stopped when dose was halved	Developed dermatitis medicamentosa which cleared when drug was discontinued	None	None	None	None
Recurrences of the Lupus	None after 1 year on 120 mg. dose	None after 7 months. No drug now being given	None for 7 months. No drug now being given	None after 5 months. No drug being given now	None after 7 months. No drug being given now	Infiltration persists. Scaling and itching improved. He is still under treatment

* This treatment proved ineffective.

† Eruption was not *completely* cleared in this time.

50 South Munn Avenue

Herbert E. Rickenberg*

Newark

Diadochokinesis in Stutterers and Non-Stutterers

Mr. Rickenberg presents a study of the ability of stutterers and non-stutterers to make shift from agonist to antagonist muscles—in other words: diadochokinesis. In this process, stutterers seem significantly slower than non-stutterers. Whether the basis is emotional or physiological is not discussed.

Speech pathologists who attach importance to organic factors in stuttering have long been interested in the rapid, repetitive movement, "diadochokinesis," of the stutterers' organs of speech.

Speech is a language process which makes use of the masticating organs for the articulation of sounds. The organic thesis implies that, while these organs retain normal functioning for their basic purpose of mastication, they do not adequately perform their much more difficult acquired speech functions.

The significance of diadochokinesis in the study of stuttering is that diadochokinesis calls forth the same precise, rapid, repetitive movement as does normal articulation.

In children, articulatory skill and the rate of diadochokinesis vary concomitantly, and are both dependent on the neuro-muscular development.

In studies of diadochokinesis of the tongue, lips and jaw of stutterers and non-stutterers, no significant difference is demonstrated when the pooled results of all the studies are evaluated statistically.[1] Furthermore, these studies were concerned with isolated muscular movement, rather than with muscular movement involved in the production of sounds.

Blackburn[2] tested the voluntary movement of the tongue, lips, lower jaw and diaphragm. He then concluded that stutterers exceeded non-stutterers in the variability of the diaphragm, tongue, lips and jaw. In hand tapping there was no significant difference. Spriestersbach[3] measured the rate of movement of the jaws, brow, tongue and lips. He found no significant differences between stutterers and non-stutterers in the rate of movements. West[4] studied the rate of voluntary repetitive movements of the jaw and brow. He found that normal males were significantly faster than stuttering males, and normal females were significantly faster than stuttering females. Cross[5] found no significant difference in the rapid, repetitive movements between the stutterers and non-stutterers with respect to the lips, jaw and diaphragm. She did find a significant difference in the diadochokinetic rate of the tongue. Stro-

*Mr. Rickenberg is the Director of the Henry C. Barkhorn Memorial, Hearing and Speech Center of the Newark Eye and Ear Infirmary. Dr. Barkhorn who died in 1948, was for many years Chairman of the Publication Committee for this Journal.

1. Strother, Charles and Kriegman, Lois: Journal of Speech Disorders, 7:325. (Dec. 1943)

2. Blackburn, W. A.: Psychological Monographs, 41:1. (1931)

3. Spriestersbach, D. C.: Unpublished Masters' thesis on file at the library of Iowa State University (Iowa City, Ia.) 1940

4. West, Robert: Journal of Neurology and Psychopathology, 21:114. (1929)

5. Cross, H. M.: Archives of Speech, 1:112. (March 1936)

ther and Kriegman [1] were interested in diadochokinetic movements of the lips, tongue, mandible and finger. There was no significant difference shown between the stutterers and non-stutterers.

These studies were not conclusive. All of this research was concerned with rather simple movements of the facial and speech musculatures in non-speech activities. It is possible that the rapid, repetitive articulation of speech sounds requires more accuracy and precision than does diadochokinesis in the form in which it has been previously studied. For this reason it was concluded that the procedure used in the present study might yield positive results in an area of investigation in which previous experiments have not.

In previous experiments there was usually the restriction of some electrical and/or mechanical apparatus about the face of the subject. Spriestersbach [3] used a contact plate for the tongue, serving as an electromagnetic key. Strother and Kriegman [1] used a face mask connected to a Marey recording tambour by a rubber tube. In testing the diadochokinesis of the tongue, West [4] and Spriestersbach [3] placed levers in the mouth which closed electric circuits upon contact. Blackburn [2] and Cross [5] placed a rubber ball between the teeth. Strother and Kriegman [1] used two tongue depressors which were bound together by rubber bands. In recording movements of the lips, Blackburn [2] and Cross[5] used lip bulbs, and Spriestersbach [3] used a lever type key. Strother and Kriegman [1] placed a small balloon between the subject's teeth. In the present study no such apparatus was needed.

PURPOSE AND PROCEDURE

It was the purpose of this study to investigate stutterers' rates of repetitive articulation of representative consonant sounds when combined in nonsense syllables with the vowel (a).

Specifically, this project was concerned with the following question: Do stutterers and non-stutterers differ in the rapidity with which they are able to move the tongue, lips and jaw in speech?

Thirty students of Brooklyn College were selected for this experiment. Fifteen were stutterers (eleven male and four female) and fifteen were non-stutterers (eleven male and four female). Mean age of the whole group was 19½.

The nine consonant sounds chosen to study diadochokinesis were: (p), (b), (m), (t), (d), (n), (k), (g) and (ng). These were selected as representatives of the movement of the lips, the tip-of-the-tongue and the back-of-the-tongue.

These consonants were combined with the vowel (a) as in *far*, thus forming a syllable. The vowel (a) was chosen to study the movement of the jaw.

To measure the diadochokinesis of the thirty subjects, individual recordings were made upon wire. Before any recordings were made each subject was instructed as to the purpose and procedure of the experiment. The need for trying to make the syllable repetitions as fast as possible was emphasized. Each subject was permitted to practice for three minutes in front of a live microphone with the metronome working.

The recording of the sounds for this experiment was transmitted through a microphone connected to a Webster-Chicago wire recorder. The time was measured by a Franz Electronic metronome set at one beat per second.

Each subject's recorded performance was later tabulated as for the the rapid repetition of the syllables in seven seconds. The first second and the last second were disregarded in the tabulation leaving the middle five seconds to be analyzed. Purpose of eliminating the first and last second was to avoid error due to starting late or running out of breath.

To obtain a statistical evaluation of the performance of the individuals and of the groups the *t* score was obtained.[6]

6. Lindquist, E. F.: *A First Course in Statistics*. New York 1942. Houghton Mifflin. Page 242.

RESULTS

A COMPARATIVE analysis of stutterers and non-stutterers, as to their ability of repetitive articulation of individual sounds in a period of five seconds was statistically evaluated. The level of the significance when comparing the stutterers with the non-stutterers for each individual sound falls into three groups. The significance of the differences is always in the same direction. The categories of significant levels are:

2 per cent, meaning that in 98 out of a hundred chances, the difference is significant.

1 per cent, meaning that in 99 out of a hundred chances, the difference is significant.

0.1 per cent, meaning that in 999 out of a thousand chances, the difference is significant.

Non-stutterers were significant at the 2 per cent level when measuring the sounds (ta) and (ga). At the 1 per cent level of significance, the non-stutterers were faster than the stutterers in their ability to repeat the sounds: (ba), (da), (na) and (ka). The non-stutterers were significantly faster than the stutterers at the 0.1 per cent level when comparing the sounds (pa), (ma) and (nga).

A composite analysis of all the individual sounds for each subject as compiled in two groups indicates that the non-stutterers were significantly faster than the stutterers at the 0.1 per cent level.

In considering the range of variation, there was a definite dichotomy among the groups. Male non-stutterers ranged from 4.6 to 3.8. Male stutterers ranged from 3.8 to 2.9. Among females, the range of the non-stutterers was 3.1 to 4.2. The range of the stutterers was from 3.1 to 2.0.

SUMMARY

1. From the student body at Brooklyn College, four groups of students were chosen and classed on the basis of stutterer or non-stutterer, male or female.

2. It appears from this study that there is a difference in the ability of stutterers and non-stutterers with regard to rapid, repetitive articulation of selected nonsense syllables. When comparing the groups as a whole, it appeared that the non-stutterers could articulate these syllables consistently faster. And this difference was meaningful at the 2, 1 and 0.1 per cent levels of significance.

3. When a composite study was made of all the individual sounds for each subject, the difference in the diadochokinetic rate of non-stutterers (their rate was faster) was significant at the 0.1 per cent level. In other words, there was only one possibility in a thousand that this difference was due to chance.

4. Among males, non-stutterers ranged from 4.6 to 3.8 sounds per second. Among stutterers the range was from 3.8 to 2.9. Among the women the corresponding figures were 4.2 to 3.1 (for non-stutterers) and 3.1 to 2.0 (for stutterers).

CONCLUSIONS

(a) With respect to the rate at which one impulse can be shifted from one group of muscles to its antagonistic group, stutterers are significantly slower than non-stutterers.

(b) It thus might be advisable to initiate therapy by using slow, repetitive movements involving speech musculature.

(c) Since these results are not confirmatory of those reported in previous experiments, further research, with a larger sample, is indicated.

77 Central Avenue

Historical Article • • •

Fred B. Rogers, M.D.*

Trenton

"Medical Doctor" Degrees of New Jersey

In this brief vignette, Dr. Rogers reminds us of a now seldom used but still legally held right peculiar to our Society: the right to confer the M.D. degree.

Current interest in establishing professional medical education in New Jersey directs attention to the conferring of medical degrees in this state. Although not widely known among its citizens, The Medical Society of New Jersey, even today, possesses the legal authority to award the degree of Doctor of Medicine. This right granted to the Society by the State Legislature in 1825 and never revoked was exercised sporadically until the beginning of the present century. A review of medical degrees in New Jersey was published in the Journal of November, 1953.

Soon after passage of the law granting the right to award the *Medicinae Doctor* degree (November 24, 1825), a suitable diploma was devised for awarding this honor. The title "Medical Doctor" was conferred either after examination or for honorary reasons, according to "rules and regulations" outlined in the *Transactions* of the Society. The honorary degree—a token of the Society's esteem of outstanding physicians—was first granted in 1831. In that year an "honourary" M.D. degree was awarded to Dr. Augustus R. Taylor of Somerset County, a Fellow (ex-president) of the Society who headed the organization in 1822 and 1830. The diploma was signed by the President and Fellows present at the annual meeting. The venerable seal of the Society (the same one in use today, a design dating from 1786) appeared on this and all subsequent M.D. diplomas—the last one, an honorary degree, being conferred in 1902.

Several forms for these diplomas, written in Latin, were published in the various Charters of the Society, as well as in its yearly volume of *Transactions*. The following examples, with English translations by the author, are reproduced from the By-Laws of the Society for the years 1851 (figures 1 and 2) and 1866 (figure 3).

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*Instructor in Medicine, Temple University School of Medicine, Philadelphia, Pa.

The author wishes to acknowledge the assistance in reviewing translations of Dean Francis R. B. Godolphin, Professor of Classics at Princeton University.

1. The Medical Society of New Jersey: *Constitution and By-Laws;* Chapter XIV of By-Laws, *Conferring the Degree of Doctor of Medicine,* (May 21, 1952).

2. Rogers, F. B.: Medical Degrees in New Jersey, Jour. Med. Soc. N. J. 50:496 (November, 1953)

3. Editorial: The Medical Society of New Jersey, J.A.M.A. 154:150 (Jan. 9, 1954)

FIGURE 1

Form of Diploma for the honorary degree of Doctor of Medicine, adopted May 9th, 1837.

Societas Medica Reipublicæ Neo-Cæsariensis,

Legibus constituta, omnibus et singulis ad quos hæ Literæ pervenirint,

SALUTEM:

Quoniam vir probus et ornatissimus quem famâ promit, scientiarum Medicinæ et Chirurgiæ cultorem, liberalium honoribus artium provectumque, secundum leges Reipublicæ Neo-Cæsariensis et hujusce Societatis, nobis commendatus est ut ad gradum honorarium Doctoris Medicinæ Chirurgiæque provehcretur: nos, igitur, Præses, cæterique Socii Societatis Medicæ Reipublicæ Neo-Cæsariensis illum ad gradum honorarium Medicinæ Chirurgiæque Doctoris libentissime proveximus, eique omnia jura privilegia et honores ad istum gradum quoquomodo pertinentia, dedimus et concessimus.

In cujus rei majorem fidem et plenius testimonium, sigillo hujusce Societatis, Præsidisque et Scribæ chirographis hocce Diploma muniendum curavimus.

Datum Trentoniæ, die ——— ante Kalendas Februarii, anno Domini Millesimo octingentesimo ——— et Societatis

PRÆSES.

L.S. } SOCII.

SCRIBA.

FIGURE 2

Form of Diploma for the degree of Doctor of Medicine, when conferred on examination, adopted May 13th, 1851.

Societas Medica Reipublicæ Neo-Cæsariensis,

Legibus constituta, omnibus has Literas lecturis,

SALUTEM:

Quoniam A. B. vir ornatus et moribus inculpatus, qui omnibus studiis ad medicinæ et chirurgiæ usum scientiamque spectantibus animum fidelitur intendit, et, arte medendi septem annos se tentavit, opinionibus hominum faventibus, nobis commendatus est ut ad gradum Doctoris Medicinæ Chirurgiæque provcheretur:

Notum sit quod placet nobis, auctoritate hacce societate collata, inquisitione ejus peritiæ diligentissima coram viris selectis et eruditis, secundum leges hujusce societatis, imprimis habita, supradictum A. B. titulo graduque Medicinæ et Chirurgiæ Doctoris adornare, eique omnia jura, privilegia et honores ad istum gradum pertinentia, dedere et concedere.

Cujus rei, hoece Diploma sigillo societatis nostræ, Præsidisque Sociorum et Scribæ chirographis ratum, testimonium sit.

Datum Trentoniæ, die ——— ante Kalendas Februarii anno Domini Millesimo octingentesimo ——— et Societatis

PRÆSES.

L. S. } SOCII.

SCRIBA.

1837

THE MEDICAL SOCIETY OF THE STATE OF NEW JERSEY,

Constituted by law, extends GREETINGS to one and all who may read this Document:

Whereas this worthy and most honored man—— ———to whom fame has brought notice as a cultivator of the disciplines of Medicine and Surgery, and advanced in the rewards of these noble professions, has been recommended to us, according to the laws of the State of New Jersey and of this Society, for advancement to the honorary degree of Doctor of Medicine and Surgery: we, therefore, the President and other Members of the Medical Society of the State of New Jersey have, with the greatest pleasure, advanced him to the honorary degree of Doctor of Medicine and Surgery, and have granted and bestowed upon him all the rights, privileges and honors howsoever pertaining to this degree.

For greater faith and more thorough witness whereof, we have ordered this diploma ratified by the seal of this Society, and by the signatures of the President and Secretary.

Given at Trenton, on the ——day of January, in the year of our Lord 18—— and of the Society.

President.

(Legal Seal)

Members.

Secretary.

1851

THE MEDICAL SOCIETY OF THE STATE OF NEW JERSEY,

Constituted by law, extends GREETINGS to all who read this Document:

Whereas, A. B., a man of honor and blameless character, who has in all his studies faithfully directed his efforts toward the knowledge and practice of medicine and surgery, and has applied himself for seven years to the art of medicine, and enjoying the esteem of men, has been recommended to us for advancement to the degree of Doctor of Medicine and Surgery:

Be it known that it is our pleasure by the authority vested in this society, after a most detailed examination into his experience, conducted before select and learned men, according to the laws of this respected society, to honor the aforesaid A.B. with the title and degree of Doctor of Medicine and Surgery, and to grant and bestow upon him all the rights, privileges and honors pertaining to this degree.

In witness whereof is this Diploma, made valid by the seal of our society, and by the signatures of the President, Members and Secretary.

Given at Trenton, on the ——day of January, in the year of our Lord 18—— and of the Society.

President.

(Legal Seal)

Members.

Secretary.

FIGURE 3

Form of Diploma for the honorary degree of Doctor of Medicine, adopted January 24, 1866 (reproduced from revised Charter of 1896).

Form of Diploma for the degree of Doctor of Medicine.

SOCIETAS MEDICA REIPUBLICÆ NEO-CÆSARIENSIS.

Legibus constituta, omnibus has Literas lecturis.

SALUTEM:

Quoniam A. B. vir ornatus et moribus inculpatus, qui omnibus studiis ad Medicinæ et Chirurgiæ usum scientiamque spectantibus animum fidelitur intendit. et opinionibus hominum faventibus, nobis commendatus est ut ad gradum Doctoris Medicinæ Chirurgiæque proveheretur:

Notum sit quod placet nobis, auctoritate hacce societate, collata inquisitione ejus peritiæ dilligentis sima coram viris selectis et eruditis, secundum leges hujusce societatis, imprimis habita, supradictum A. B. titulo gradu-que Medicinæ et Chirurgæ Doctoris adornare, eique omnia jura, privilegia et honores ad istum gradum pertinentia, dedere et concedere.

Reipublicæ Neo-Cæsariensis illum ad gradum honorarium Medicinæ Chirurgiæque Doctoris libentissime proveximus, eique omnia jura privilega et honores ad istum quoquomodo pertinentia, dedimus et concessimus.

In cujus rei majorem fidem et plenius testimonium, sigillo hujusce Societatis, Præsidisque et Scrivæ chirographis hocce Diploma muniendum curavimus.

Datum , die—— anno Domini ——et Societatis.

PRÆSES.

{ L. S. } { SOCII.

SCRIBA.

1896

THE MEDICAL SOCIETY OF THE STATE OF NEW JERSEY,

Constituted by law, extends GREETINGS to all who read this Document:

Whereas, A. B., a man of honor and blameless character, who has, in all his studies, faithfully directed his attention toward the knowledge and practice of Medicine and Surgery, and who enjoys the esteem of men, has been recommended to us for advancement to the degree of Doctor of Medicine and Surgery:

Be it known that it is our pleasure, by the authority vested in this society, after due examination into the details of his experience, conducted before select and learned men, according to the regulations of this society, to honor the aforesaid A. B. with the title and degree of Doctor of Medicine and Surgery, and to grant and bestow upon him all the rights, previleges and honors pertaining to this degree.

We have advanced him with great pleasure to the honorary degree of Doctor of Medicine and Surgery of the State of New Jersey and have granted and bestowed upon him all rights, privileges and honors howsoever pertaining to that degree.

For greater faith and more thorough witness whereof, we have ordered this Diploma ratified by the seal of this Society and by the signatures of the President and Secretary.

Given, on the ——day of ————————, in the year of our Lord ——— and of the Society.

President.

(Legal Seal)

Members.

Secretary.

Donnelly Memorial Hospitals

Juvenile Arthritis

N. J. Johnson and K. Dodd (M. Clin. North America 39:459, 1955) point out that prognosis in juvenile rheumatoid arthritis is gloomy. About 50 per cent of patients remain incapacitated to some degree. Many subjects lead a bed-and-chair existence. Cortisone produces striking results in patients with severe constitutional symptoms but remission can be maintained for scarcely more than a few months. Phenyl butazone is at present showing great promise in juvenile rheumatoid arthritis. "Our limited experience indicates that, as with other anti-arthritics, subjective improvement comes earlier, and in the chronic cases is much more marked than objective changes in the joints."

Proteus Diarrhea and Antibiotics

Writing in the Journal of the Indiana Medical Association (48:597, June 1955), Loh and Baker report tremendous proliferation of Proteus in the intestinal tract following administration of chlortetracycline and oxytetracycline. The question arose as to whether Proteus overgrowth causes diarrhea. Thirteen normal young adults were each given 250 mg. chlortetracycline orally 4 times daily for 5 days. Marked proliferation of P. *mirabilis* occurred in 9 subjects, none of whom developed diarrhea. Absence of diarrhea despite overgrowth of Proteus may be due to lack of invasiveness of the organism. On the other hand, invasion may have occurred but not in sufficient degree to cause diarrhea or diarrhea may have failed to develop for unknown reasons.

Trustees Meeting: April 8, 1956

At their April 8 meeting, the Trustees:

—Received a report from the President indicating that Dr. Butler had attended 23 meetings and conferences in the two previous months.

—Agreed to cooperate with the State Department of Institutions and Agencies in developing a program of psychiatric technics for general practitioners.

—Approved, in principle, the practice of letting reputable pharmaceutical houses sponsor or underwrite educational courses for physicians, subject to the separate, individual approval of each project.

—Agreed to cosponsor a course in obstetrics to be developed by Seton Hall College of Medicine.

—Decided to re-establish the committee on rehabilitation as a special committee to the subcommittee on public health.

—Agreed to name a representative to the New Jersey Welfare Council.

—Endorsed a State Health Department's study of air pollution in northern New Jersey.

—Approved a Society budget of $172,649. for 1956-7.

—Approved a per capita assessment of $30 for 1956-7.

—Received from the Executive Officer a report indicating attendance at 24 meetings and conferences in the last two months.

—Approved of the local professional program of the American Cancer Society.

—Endorsed a proposal to set the annual reregistration fee for physicians at "an amount sufficient to defray administrative expenses, not to exceed $5."

—Expressed disapproval of bill S-90. (This bill would provide that no child should be refused poliomyelitis vaccination for any reason whatsoever).

—Approved of bill A-3 as amended. (This would license practical nurses).

—Approved, in principle, bill A-201 which provided, under certain conditions, for medical and hospital coverage for state employees.

—Approved certain recommendations of the Subcommittee on Medical Practice. See Welfare Committee report which follows.

—Approved certain recommendations made by the Subcommittee on Public Health. See Welfare Committee report which follows.

—Received the following from the special joint committee (with the Bar Association) on medico-legal testimony:

1. Both organizations will place before their respective House of Delegates a resolution, similar in both instances, wherein a committee would be named to act as a state committee. Such committee would consist of approximately three physicians and three lawyers.

2. In cases where attorneys find it impossible to get medical testimony in malpractice cases, the cases would be referred to the state committee. If that committee felt there is no merit to the case, it would advise the attorney not to prosecute the case and eliminate embarrassment on the part of any physician. If the case has merit, the committee would help the attorney involved to get proper medical testimony. This latter does not mean the committee would necessarily get a physician, or physicians, from the same county, but it would help the attorney get medical testimony.

3. If such a resolution is passed by the House of Delegates of the Bar Association and the Medical Society, it would be implemented by setting up a high level committee, so if a case comes to pretrial conference before the judiciary, the judge involved might ask if the case had been acted upon by the committee and what was the committee's judgment of the case. And, if the case had not been before the committee, and the lawyer claims he cannot get medical testimony, it is hoped the judge will ask that the case be sent to the committee to determine its merit.

The Trustees approved the general principle outlined above and directed it be drafted into suitable resolution form.

—Directed letters to the Governor and the State Commissioner of Health, clarifying our position on the administration of poliomyelitis vaccination, making it clear that failure to administer the vaccine was, in many cases, due to inadequate supplies or uneven distribution of the vaccine.

190th Annual Meeting—May 12 - 16, 1956

Haddon Hall, Atlantic City

Official Attendance

County	Delegates	Members	Total
Atlantic	10	90	100
Bergen	35	35	70
Burlington	4	13	17
Camden	16	45	61
Cape May	2	5	7
Cumberland	6	18	24
Essex	53	202	255
Gloucester	3	12	15
Hudson	28	44	72
Hunterdon	2	4	6
Mercer	24	53	77
Middlesex	15	30	45
Monmouth	15	53	68
Morris	14	24	38
Ocean	3	8	11
Passaic	20	43	63
Salem	3	7	10
Somerset	6	21	27
Sussex	2	2	4
Union	34	67	101
Warren	2	10	12
Fellows, Officers, Trustees, Councilors	21		21
	318	786	1,104

Physician Guests	109
Physician Exhibitors	25
TOTAL PHYSICIAN REGISTRATION	1,238
Auxiliary Members	402
Visitors	301
Exhibitors	244
TOTAL REGISTRATION	2,185

FIVE-YEAR COMPARATIVE REGISTRATION FIGURES

Year	Physicians	Others	Total
1956	1,238	947	2,185
1955	1,040	790	1,830
1954	1,231	996	2,227
1953	1,012	871	1,883
1952	1,010	785	1,795

Scientific Exhibit Awards

Class I—Scientific exhibits of individual investigations, judged on the basis of originality and excellence of presentation:

First Place: The Problem of the Non-Adherent Surgical Dressing

James F. Connell, Jr., M.D., William Phillip, M.D., Frank Gilbertson, M.D., and Louis M. Rousselot, M.D., St. Vincent's Hospital and New York University, New York, N. Y.

Second Place: Surgical Revascularization of the Heart

N. A. Antonius, M.D., L. G. Massarelli, M.D., A. D. Crecca, M.D., J. J. McGuire, M.D., and J. V. Crecca, M.D., St. Michael's Hospital, Newark.

Third Place: Use of Trilene® in Obstetrical Labor

Gene L. D'Alessandro, M.D., Rolf Vlatten, M.D., George Mathcke, M.D., and L. Felmly, M.D., Presbyterian Hospital, Newark.

Honorable Mention: The Roentgen Diagnosis of Hyperrugosity of the Stomach

Daniel Wilner, M.D., Atlantic City; and Robert Sherman, M.D., New York, N. Y.

Class II—New Jersey Exhibitors:

First Place: Treatment of Cardiovascular Emergencies

Arthur Bernstein, M.D., Franklin Simon, M.D., J. J. Silverman, M.D., and Harold Trachtenberg, M.D., Newark Beth Israel Hospital, Newark.

Second Place: Tomography in the Management of Pulmonary Tuberculosis

Irving J. Selikoff, M.D., David Roth, M.D., and Robert H. Joelson, M.D., The Paterson Clinic and Barnert Memorial Hospital, Paterson.

Third Place: Treatment of Carcinoma of the Bladder

Irving Maisel, M.D., Maxwell Malament, M.D., and Kenneth Forbes, M.D., Veterans Administration Hospital, East Orange.

Honorable Mention: Aspiration Biopsy in Head and Neck Surgery

William G. Bernhard, M.D., W. Franklin Keim, M.D., Harold Grubin, M.D., Hlemuth Wanner, M.D., and Gerhard Sewekow, M.D., Hospital of St. Barnabas and for Women and Children, Newark.

Welfare Committee Actions: March 11, 1956

On March 11, the Welfare Committee:

—Received and endorsed a proposed professional information program from the New Jersey Division of the Cancer Society.*

—Endorsed a proposed Seton Hall "Recent Advances in Obstetrics" course.*

—Supported the AMA position on HR-7994. This bill would provide, in government facilities, and through subsidized private health insurance, medical care for dependents of Army and Navy personnel. The servicemen would pay 30 per cent and the government 70 per cent of the premium. The AMA position is that emphasis should be placed on the maximum utilization of civilian accommodations.*

—Agreed with the Subcommittee on Legislation that a $2 fee be charged for the annual re-registration of M.D. licenses.

—Disapproved of A-5, which would regulate the practice of physical therapy, allowing chiropractors but not doctors' assistants to perform physical therapy or supervise its administration.

—Endorsed A-22 which permits an injured employee to select a physician of his own choosing under the Workmen's Compensation Act.

—Concurred in A-34 which would permit municipalities to restrict parking in front of doctors' offices.

—Received and approved a report of the committee studying the corporate practice of medicine. The report, in summary, follows:

> About 20 per cent of our members are engaged in some sort of contract medicine. Predominantly involved were pathologists and radiologists. Reports received from 69 per cent of the radiologists and 66 per cent of the pathologists indicate that, generally speaking:
>
> (a) The hospital is the billing agent.
> (b) Bills are submitted in the name of the hospital, not in the name of the physician rendering the service.
> (c) The hospital is the collecting agent.
> (d) About one-half of those reporting signified having only an oral contract with the hospital.
> (e) There is 78 per cent radiologic service available in private offices; only 39 per cent pathologic service available in private offices.
> (f) The majority of radiologists work on a percentage basis, while the majority of pathologists work on a salary basis.
> (g) About one-half of the radiologists and pathologists have control of their departments.
> (h) About one-half of the radiologists and pathologists feel their services are being exploited.
> (i) Most of the radiologists and pathologists feel the patient is not being exploited.

The Subcommittee on Medical Practice has been guided by the following definition of the corporate practice of medicine adopted by the A.M.A. in 1950 and confirmed by the subcommittee last September:

> A physician should not dispose of his professional attainments or services to any hospital, lay body, organization, group, or individual, by whatever name called or however organized, under terms or conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned.

The Welfare Committee approved the recommendation of the subcommittee.

Recommendation: We have investigated the extent of the corporate practice of medicine in New Jersey; the above report is our finding, and from this we recognize that a majority of radiologists and pathologists are involved with hospitals in the corporate practice of medicine; and we recommend that some steps be taken to correct this situation.*

—Received the following memorandum from pathologists in New Jersey:

> Our proposal is to transfer coverage for all laboratory medicine from Blue Cross to Blue Shield. This would be in accord with the basic principle of each plan. This would help settle once and for all the question of hospital-pathologist relationships and would put the *entire* control of laboratory medicine (for its betterment) where it belongs—in the hands of the pathologists.
>
> Pathologists have developed a minimum fee schedule. They realize it may require months of study by a committee representative of the parties involved to develop the implementation of their proposal. They emphasize, however, that present trends must be reversed lest all hospital-medical practice and all its subdivisions become dominated and "sold" by hospital corporations and lay boards. The mechanics for effecting the reversal must be fair to all concerned.

The Welfare Committee took no specific action on the proposal at this time, because it is tied in with the report and recommendation on Corporate Practice of Medicine.

The Welfare Committee approved the following:

> That copies of all future news releases issued by the State Department of Health be sent to the secretaries of the county medical societies.*
>
> That The Medical Society of New Jersey ask the State Department of Health to distribute vaccine from state and federal sources to biologic stations, that such vaccine be made available to physicians

*Subsequently approved by the Board of Trustees

in their offices, and that the Health Department replenish the vaccine as fast as possible.*

The Welfare Committee disapproved a third recommendation that no clinics or physicians in their offices be allowed to give second vaccine injections until all eligible people have received first injections, regardless of reason.

The Welfare Committee approved the following recommendations:

1. Cooperation with the New Jersey Division of Motor Vehicles in determining the value of hearing in protecting public safety and also in outlining adequate tests for operators of motor vehicles.*

2. Since the New Jersey State Division of Motor Vehicles in Trenton has established a clinic to examine individuals who have been involved in fatal accidents, it be suggested these same individuals be tested with the simple screening audiometer used in the public schools. As each clinic is organized it be suggested that a screening audiometer be installed, and a technician trained to use it under the supervision of an otologist. In a few years, statistics thus obtained will act as a basis for further recommendations.*

3. That every effort be continued to establish Hearing and Speech Research Centers at hospitals in Trenton and Atlantic City.*

4. That every county medical society in New Jersey be organized and activated into units to support this movement.*

The following recommendation was presented by the Subcommittee on Public Health and approved by the Welfare Committee.

Whereas, there is a great need for additional psychiatric beds throughout the state both for children and adults;

Whereas, the private physician cannot and need not confine his patients in a state institution for all mental illness;

Whereas, no adequate facilities exist for short time psychiatric care of children and adults.

Be It Therefore Resolved, that all encouragement be given to medical, governmental, and lay organizations in their attempts to establish psychiatric units in all general hospitals.*

Salk Vaccine: 1956 Emergency Schedule

The following comes from the National Foundation for Infantile Paralysis:

1. Do not give "booster" shots between now and July 1, 1956. There is minimal risk if, in fact, any at all, in giving primary or booster shots *during* the polio season.

2. Use all available vaccine immediately. Do not save it for "second shots," even though a sterilely punctured vial of vaccine can be kept under refrigeration for an indefinite length of time without impairing either safety or potency of the vaccine.

3. The increasing supply of vaccine should be depended upon for second injections in 1956. The exact interval recommended between the first and second doses is not crtical, so long as it is not *less* than two weeks. In fact, longer intervals seem to be advantageous. Therefore, the second dose may be given at any time without losing the benefit of the first.

4. However, the third dose should be given not less than seven months after the second but may be given at any length of time thereafter.

On the basis of reports from the Surgeon General of the Public Health Service we believe that an adequate supply should be available for distribution before the seasonal advent of poliomyelitis in the summer of 1956. The supply should be about enough to provide a high degree of protection against paralytic poliomyelitis to all children 6 months through 14 years age group and to pregnant women who request it. Nationwide, there are about 50 million individuals in these categories. Probably 15 million children have already received one or more injections of Salk vaccine. This leaves about 35 million children and some to be vaccinated on an emergency basis before the 1956 season.

Granting rapid and equitable distribution and no unanticipated delays in processing and releasing vaccine (which requires a minimum of 120 days), we should have just about enough vaccine to give at least one and usually *two injections* each to 35 million people.

The *ideal* dosage schedule currently recommended is: Two 1 cubic centimeter injections, spaced two to six weeks apart, with a third ("booster") injection not earlier than seven months later. Ideally, the first two injections should be given immediately *after* the previous polio season, in the late fall, with the booster injection being administered just *before* the subsequent polio season. This schedule is impossible to follow under the emergency conditions of 1956.

Reports from 30 state health officers, evaluating the 1955 vaccine program, showed about 80 per cent effectiveness even though three inoculations, as recommended, had *not* been given. This compilation compares experience among 5.2 million unvaccinated children and 4.8 million children who received one or more doses, but mostly one dose, of vaccine. Even under the epidemic conditions that prevailed in Massachusetts in 1955, a high rate of protection (60 per cent against paralytic poliomyelitis) was reported from just one dose of the vaccine used in that state.

The first injection of vaccine of the potency that prevailed in 1955 did not "take" in about 20 per cent of the children inoculated. However, a substantial proportion of those who fail to acquire antibody on the first injection, attain antibody, and a primary sensitization, with a subsequent injection.

For a true booster effect, in which antibody reaches very high levels, equal to or exceeding those produced by naturally aquired immunity, the injection following primary sensitization must be delayed at least seven months or longer.

An increasing vaccine supply may be anticipated as the polio season approaches. There will also be a greater public interest in getting vaccination at this time; but because of the time required to induce full immunity, it would be advantageous to give the first dose as early as possible to all within the stated age groups.

HART E. VAN RIPER, M.D.
Medical Director
National Foundation for Infantile Paralysis

New New Jersey FACP's

At its Los Angeles convocation in April 1956, the American College of Physicians elected the following New Jersey doctors to Fellowship:

Marvin C. Becker of Newark
William Levison of Newark
Alva Jenkins of Englewood

At the same time, the following New Jersey physicians were elected to Associate status in the ACP:

Max Braitman of West New York; Charles W. Clarke of Summit; Bernard Eisenstein of Englewood; Rubin Grossman of Bayonne; H. Leonard Levenson of Trenton; Hugh F. Luddecke of Morristown; Thomas C. Rommer of Newark; John E. Schults of Tenafly; Horace M. Shaffer of Trenton; Milton Shoshkes of Newark; George F. Stoll of Belleville, and Louis E. Zimmer of Newark.

Seton Hall Announces Faculty Appointments

The Seton Hall College of Medicine and Dentistry announces the following faculty appointments:

P. J. Harman, Ph.D. of New York, as head of the department of anatomy.

Charles M. Berry, Ph.D. of New York, as professor of anatomy.

May B. Hollinshead, Ph.D. of New York, as assistant professor of anatomy.

Christian A. Heyde, Ph.D. of New York, as assistant professor of anatomy.

J. P. Tassoni, Ph.D. of New York, as assistant professor of anatomy.

Frank D. Anderson, Ph.D. of New York, as assistant professor of anatomy.

Robin Curtis, Ph.D. of New York, as instructor in anatomy.

David F. Opdyke, Ph.D. of Rahway, as head of the department of physiology.

Raymond L. Garner, Ph.D. of California, as head of the department of biochemistry.

Richard G. Mason, Ph.D. of Rahway, as assistant professor of physiology.

Arthur J. Kahn, Ph.D. of Washington, D. C., as assistant professor of physiology.

Obituaries • • •

DR. HUGH W. BAKER

On the first day of May, 1956, Dr. Hugh W. Baker, one of the senior members of the Cumberland County Medical Society died at his home in Vineland. Born in upstate New York in 1879, Dr. Baker received his M.D. degree from the University of Pennsylvania in 1902. He practiced for 15 years thereafter in Deposit, N. Y. After World War I Dr. Baker came to south Jersey and established an office in Vineland. Here he ministered to the needs of the people of Cumberland, day in and day out, winter and summer, for 37 years. Dr. Baker was, until 1930, a family doctor who gloried in the appellation of "general practitioner." Becoming increasingly interested in otolaryngology, he did graduate work in that specialty from 1931 to 1934, and then limited his practice to it. Dr. Baker was active in Masonic and other civic affairs.

DR. ABRAM P. BLAKEY

On March 26, Dr. Abram P. Blakey died, as he would have wished, in harness. He was making a professional call when seized by a fatal heart attack. A lifelong resident of Jersey City (where he was born in 1898) Dr. Blakey earned his M.D. at Georgetown in 1924. He became interested in anesthesiology and was one of the pioneer users of spinal and other types of non-inhalation anesthesia. However, Dr. Blakey never abandoned his interest in the total patient, and to the day of his death was a busy general practitioner. He was the anesthesiologist to the Greenville Hospital, and was active in committee work in the Hudson County Medical Society.

DR. FRANK CERRETO

Dr. Frank Cerreto, 50, of Newark, died on March 28, 1956 while attending a patient at a hospital. Born in Newark, Dr. Cerreto was graduated from the undergraduate college at Fordham in 1925 and from the medical school of the University of Rome in 1929. He interned at the Columbus Hospital in New York and then returned to his native city for a second internship year. He was a general practitioner, and was affiliated with the staff of the Columbus Hospital in Newark.

DR. JAMES V. CONWAY

At the untimely age of 49, Dr. James V. Conway died on April 16, 1956. Born in Orange, Dr. Conway was graduated from the medical school of George Washington University in 1934. He then did graduate work in otology at New York University. During the war, he served as a medical officer in an Army hospital in Great Britain. Dr. Conway was an Assistant at the Eye and Ear Infirmary in Newark and an Associate in Laryngology at the Elizabeth General Hospital. Dr. Conway was also trained as a bronchoscopist and served several hospitals in that capacity. Dr. Conway was active in committee work for the Union County Medical Society.

DR. ALBERT B. DAVIS

One of Camden County's senior obstetricians, Dr. Albert B. Davis died on April 22, 1956. Born in Camden in 1880, Dr. Davis moved his residence to Haddonfield in 1924. He received his M.D. degree at the University of Pennsylvania in 1905 and returned to his native city for internship. In 1907 he entered private practice in Camden, first as a family doctor, then developing increasing interest in obstetrics. In 1910 he became an Assistant Obstetrician at the Cooper Hospital, and by 1919 had become chief of the obstetrical service there. He remained actively engaged in obstetrics until 1952, and he then retired on the 47th anniversary of his earning his M.D. degree. Dr. Davis was active in committee work in the Camden County Medical Society. He was an FACS, and active in church affairs in Camden County.

DR. MARGARET GERHART

Dr. Margaret Gerhart, a Mantua practitioner, died on April 7, 1956 at the age of 41. An alumna of the Women's Medical College (class of 1937) Dr. Gerhart was a general practitioner, affiliated with the West Jersey Hospital. In private life, she was Mrs. Charles R. Hodges of Woodbury. Dr. Gerhart was active in the affairs of the Gloucester County Medical Society.

DR. CARL A. GESSWEIN

On March 19, 1956, Dr. Carl Gesswein, one of Monmouth County's senior practitioners, died at the Riverview Hospital. Dr. Gesswein was born in Ohio in 1881 and in 1904 won his M.D. degree at the medical school of the University of Illinois. He came to New Jersey the following year, and after practicing in Plainfield from 1905 to 1916, moved to Matawan in 1916. He served the people of Monmouth County for 40 years. He was president of the Matawan Bank, and active in Masonic circles. Dr. Gesswein was school physician in Matawan and borough physician in Holmdel. He was affiliated with the Monmouth Memorial, the Riverview and the South Amboy hospitals. He was chief of emergency medical services of the Matawan Civil Defense Council.

DR. FRANCIS H. GLAZEBROOK

One of the deans of Morris County medicine, Francis H. Glazebrook, is dead. Dr. Glazebrook died on March 11, 1956 at the fine age of 79. He was well known for his activities as chief medical director of the New York Stock Exchange, a position which he held for a full decade beginning in 1928. It was under Dr. Glazebrook's direction, that the Stock Exchange built and developed its now famous general medical-surgical clinic, one of the most unusual dispensaries of its kind.

Dr. Glazebrook was born in Charlottesville, Virginia in 1877. His father, Otis, was a statesman of considerable prominence at the turn of the century and was this country's Consul General to France in World War I. Francis Glazebrook was graduated from Cornell Medical School in 1900, and opened an office for general practice in Morristown. He soon became affiliated with the surgical staff of both hospitals there and was a surgical consultant to Greystone Park. He was active in many civic affairs in Morris County. He served also as surgeon to the D. L. & W. railroad, and in 1928 was invited to develop the stock exchange clinic. Dr. Glazebrook was a past president of the Morris County Medical Society, and a vice-president of the New Jersey Surgical Society.

DR. CHARLES M. HARRIS, SR.

Dr. Charles M. Harris, Sr. of Jersey City died suddenly on March 9, 1945 at the age of 57. Born in Alabama in 1899, Dr. Harris was graduated from Boston University Medical School in 1924. He was a diplomate in otolaryngology and was affiliated with that service in the Jersey City Medical Center. Dr. Harris had a Pennsylvania license and also was a frequent consultant in otolaryngology in Philadelphia.

DR. OSCAR JACKS

Dr. Oscar Jacks died on April 29, 1956. Born in Austria in 1891, Dr. Jacks was brought to this country in 1895. In 1914 he was graduated from Bellevue Medical College, and for two years thereafter was an intern, later an obstetrical resident at the Jersey City Medical Center. Dr. Jacks was active in the Elks and also in civic affairs in Hudson County. He was a family doctor in Jersey City, and was one of the senior physicians for the Jersey City Board of Education. Dr. Jacks was a trustee of the Fairmount Hospital and was an associate on the obstetrical service of the Greenville Hospital.

DR. HARVEY G. MENSCH

Dr. Harvey G. Mensch died on May 2, 1956. Born in Pennsylvania, in 1926 he was graduated from the Jefferson Medical College. He returned to his native Pittsburgh to intern at the Allegheny General Hospital there. After doing general practice in western Pennsylvania, Dr. Mensch entered the army where he served as a medical officer during World War II. He then became interested in psychiatry, and did graduate work in that specialty in New York and Philadelphia. He then moved to Elizabeth, joined the Union County Medical Society and became a member of the psychiatric service at the Elizabeth General Hospital. Dr. Mensch was also active in industrial medicine.

DR. PATRICK H. W. MURPHY

Dr. Patrick H. W. Murphy died in Jersey City on April 6, 1956. Born in that city in 1900, Dr. Murphy was graduated in 1928 from the medical school of Georgetown University. Dr. Murphy was active in the Holy Name Society and in the Hudson County Medical Society. He was an Assistant Surgeon at the Christ Hospital in Jersey City, and on the active staff of the Holy Name Hospital in Teaneck. He was an induction board examiner during World War II. In his later years he became increasingly interested in internal medicine, particularly cardiology. He was, at the time of his death, an attending internist at the Hudson County Hospital in Secaucus.

DR. MEYER NOTKIN

At the untimely age of 49, Dr. Meyer Notkin died suddenly on the golf links of a country club on April 25, 1956. Born in New York, Dr. Notkin's family brought him to Paterson when he was a

child. He received his M.S. from the University of Michigan in 1928 and his M.D. there in 1932. He interned at St. Joseph Hospital in Paterson from 1932 to 1933 and then entered general practice. Always interested in cardiology, be began to devote much of his attention to that specialty. In the spring of 1941 (months before Pearl Harbor) he accepted a lieutenant's commission in the medical corps, later the Air Forces. He became chief of cardiovascular diseases at a U. S. Army Hospital. His active duty military career extended for almost five years.

Dr. Notkin became a diplomate in internal medicine. For some years he was president of the Passaic County Heart Association. He was a Fellow of the American College of Cardiology.

DR. HENRY W. ROWAN

On April 12, 1956, at the age of 62, Dr. Henry Rowan, director of obstetrics at the Mercer Hospital, died after a brief illness. Born in Arkansas in 1894, Dr. Rowan was graduated in 1920 from the medical school of the University of Pennsylvania. After a year's internship in Youngstown, Ohio, he became interested in obstetrics and took a residency at the New York Lying-In Hospital. He then spent two years in Europe, some time in Scotland, some in Vienna, doing graduate work in gynecology and obstetrics. In 1927 he came to Trenton, opened his office for the practice of obstetrics, joined the staff of the Mercer Hospital, and served the people of Mercer County for almost 30 years.

Dr. Rowan was active in the affairs of the Mercer County Medical Society. He was one of the pioneer members of the New Jersey Obstetrical and Gynecologic Society, and served the Mercer Hospital in all capacities from Assistant to Chief in obstetrics.

DR. VINCENT J. SHEERAN

On March 5, 1956, Bishop Fulton J. Sheen administered the last rites to Dr. Vincent J. Sheeran, who died of a heart attack while on vacation in Miami. Dr. Sheeran was born in Jersey City in 1905 and in 1930 earned his M.D. at Georgetown. During the second world war he was an officer in the medical corps of the Navy. Dr. Sheeran was actively affiliated with St. Francis Hospital and the Margaret Hague Hospital and was on the staff of the county general hospital at Secaucus. He was also active in the Holy Name Society of St. Aloysius Church as well as in committee work in the Hudson County Medical Society.

DR. GORDON A. STEPHENSON

A heart attack took the life of Dr. Gordon A. Stephenson on May 4, 1956. Dr. Stephenson was a surgeon-in-chief at the Overlook Hospital in Summit. Born in Buffalo in 1903, Dr. Stephenson earned his M.D. at the medical school of the University of Buffalo in 1929. He was brought to New Jersey to intern at the Orange Memorial Hospital, and —finding that he liked our state—he settled in New Jersey and served this state for the rest of his life. He did general practice in Summit in 1930 and 1931 and then decided to go into surgery. Closing his office, he took a full 2-year residency-fellowship in surgery at the Jersey City Medical Center. Dr. Stephenson also served as surgeon to the Bell Laboratories and as an instructor at the Post Graduate Medical School in New York.

Dr. Stephenson was active in the affairs of the Union County Medical Society and was a pioneer member of the Summit Medical Society. He was also a Fellow of the American College of Surgeons.

DR. JOHN D. TIDABACK

Summit's senior radiologist, Dr. John Daniel Tidaback died on April 11 at the age of 75. Born in Ogdensburg, N. Y., Dr. Tidaback's family sent him to Peddie for his secondary schooling, and there he formed an attachment to New Jersey. In 1909 he was graduated from Albany Medical College, and entered practice in Newark. In 1917 he left to join the army and after serving through World War I, he returned to New Jersey, opened an office in Summit and began to concentrate in radiology. He was on the staffs of both hospitals in Morristown and for years was radiologist to the Overlook Hospital in Summit. He was one of the country's earliest diplomates in radiology. He helped found the New Jersey Radiologic Society and was one of its early presidents. He was active in many civic organizations.

DR. HERBERT H. WILSON

Dr. Herbert H. Wilson died on March 18. Born in Bridgeton in 1879, he was graduated in 1903 from the University of Pennsylvania. He was a general practitioner of the old school, active in civic and community affairs throughout southern New Jersey. Dr. Wilson served the Cumberland County Medical Society in almost every office and capacity. He was a past-president of the Society and also a past-president of the Kiwanis Club. He was active in Masonic and church affairs.

Authors' Clinic • • •

Your Armed Forces Medical Library

Every would-be medical author has to know how to search the literature. This was reviewed in the December, 1955 issue of this JOURNAL —see page 649. It is perhaps well to tell you in more detail about the many services which the Armed Forces Medical Library will make available to you. This library is the hemisphere's largest collection of medical-dental-pharmaceutical literature. It has over a million items. To tap this vast resource, simply write to the Director.*

At one time, the Library's major product was the Index-Catalogue of the Surgeon-General's office. However, this lists nothing newer than 1950, so it is rapidly becoming obsolete except as a source for historical material. To replace this Index-Catalogue, the Armed Forces Medical Library now provides the following helpful services:

The Current List of Medical Literature: This is now the Library's top project and it is the best all-around source of bibliographic citations in medicine, pharmacy, and dentistry. It consists of monthly booklets, with the June and December issues cumulating the citations of the previous five months. The *Current List* is, or should be, shelved in the library of any large medical society, medical school, university, or academy of medicine. A practitioner may obtain a personal subscription at $13.50 per year by sending a check for that amount to the Superintendent of Documents, Government Printing Office, Washington 25, D. C., and asking for the Current List of Medical Literature (Armed Forces Medical Library).

Each issue consists of (a) The Register, (b) The Topical Index, and (c) The Author Index. In the Register, the journals covered in that issue are grouped alphabetically, and then under each journal title the articles are listed, with a key number for each article. In the "Topical Index" section are headings and subheadings. You search the literature by starting with this "Topical Index," looking under the desired heading and subheading noting the key number of the relevant articles. Then you go back to the Register and look under the key number to get the full citation. The Author Index is of less use, but is handy if the researcher knows only that a certain author wrote an article in a certain year, and wants the specific title and exact citation.

Loan Service: You can borrow almost any book or journal in any branch of medicine, dentistry, pharmacy, surgery, or technology. You may borrow five items at a time and keep them for two weeks. Yo do this through your local (city or county) general library. There is no charge except for express or postage. The borrower pays this both ways. If your local librarian is unfamiliar with this, have him write to the Circulation Section, Reference Division, Armed Forces Medical Library.*

Ancient Medical and Dental Books: This Library has a History of Medicine Division at 11000 Euclid Avenue, Cleveland 6, Ohio. This Division has available some 17th and 18th century medical and dental material.

Photostats: If you know what you want, you can buy photostats of articles, at a rate of 10 cents a page. Minimum fee is 50 cents. First write to the Library* and ask for form AFML-48, and then send that in together with your check. Do not ask the Library to photostat an entire Journal or book, since this may conflict with copyright laws.

Reference Service: If you want a list of articles on a specific subject, try your local resources first. If these fail, write to the Armed Forces Medical Library,* state your problem, and tell them what years you want covered. They may be able to prepare a bibliographic list for you, though this is not one of their prime duties.

Translations: If you need an interpreter to read and translate a scientific article in Swedish, Slovak, or Siamese, ask the Armed Forces Medical Library to recommend a translator. They keep a register of medical interpreters.

Free Microfilms: You can borrow, for 90 days, single microfilm copies of original articles. This is arranged through your local city or county (general) library. If the librarian does not know about this, tell him to ask for form AFML-48 from the Armed Forces Medical Library.*

Microfilm Rental: If you have access to facilities for reading microfilms, you may buy microfilms of selected pages in journals or books at the rate of fifty cents for each fifty pages. You apply for these microfilms on form AFML-48.

HENRY A. DAVIDSON, M.D.

*The address of the Armed Forces Medical Library is 700 Independence Avenue, S. W., Washington 25, D.C.

County Society Reports • • •

Atlantic

The regular meeting of the *Medical Society of Atlantic County* was held at the Children's Seashore House on February 10. The President, Dr. Peter H. Marvel, presided.

Speaker was William L. Watson, M.D., Associate Professor of Surgery, Bellevue Medical Center. His subject was "Newer Concepts of Cancer."

The business meeting was then opened by President Marvel. The minutes of the previous meeting were approved as published in the *Bulletin*.

Dr. Molitch reported that every possible aid had been given to members involved in "narcotic troubles." Dr. Molitch recommended that any member with illness be under the care of another physician and should not prescribe narcotics for himself.

A letter from Dr. R. White related that each member of the county society had been asked to send a note or telegram to Washington to express opposition to H.R. 7225. The response was tremendous. Within twenty-four hours Dr. White had heard from eighty members. At the time of the writing replies had been received from ninety-six members, and except for one member, all had shown their willingness to cooperate.

Dr. Molitch reported on the directive released by the Department of Institutions and Agencies concerning welfare patients in nursing homes. Apparently, the nursing home proprietor is to receive $18 a month more than at present, to cover the cost of drugs and fees of attending physicians. The necessity for medical care and drugs to be given is at the discretion of the proprietor, who may call any physician he desires. The Society then adopted a motion opposing in principle and practice the action taken by the Department of Institutions and Agencies in reference to nursing homes.

Dr. Leonard Ellenbogen introduced a resolution, submitted by the New Jersey Radiological Society, as follows:

Whereas, it is evident that payments of certain medical services are now incorporated in Blue Cross Hospitalization Plan of New Jersey contracts for direct payment to the subscribing hospitals, and

Whereas, this concept is foreign not only to our ethical principles, but also to those of the American Medical Association,

Be It Resolved, that the Atlantic County Medical Society go on record as demanding the deletion of such payments for medical services from the Blue Cross Hospitalization Plan of New Jersey and any other statement in the Blue Cross contract implying coverage of medical services; and that such services be included in the Blue Shield Medical Surgical Plan of New Jersey.

Be It Further Resolved that a copy of this resolution be sent to the State Medical Society of New Jersey for appropriate action.

This resolution was referred to the Advisory Committee to Medical-Surgical Plan and Insurance.

Dr. James Mason, Sr., read the following in memory of Dr. Edward Foy Uzzell.

Whereas, Almighty God, in His infinite wisdom has called our friend and colleague, Dr. Edward Foy Uzzell to his eternal reward, and

Whereas, Dr. Edward Foy Uzzell has been an honored member of the medical profession in Atlantic City for thirty-six years, a member and Past President of the Atlantic County Medical Society, a member of the American Medical Association and of the Society of Surgeons of New Jersey, a member, Past President and Chief of Staff of the Atlantic City Hospital, and Fellow of the American College of Surgeons, and

Whereas, he has been a devoted husband and father to his family; a worthy citizen of our community; active in its civic organizations and generous to its charities, and

Whereas, Dr. Edward Foy Uzzell brought to us his infectious sense of humor, and was beloved and respected by peoples of all classes, creed, and color,

Be It Therefore Resolved that we who were his professional associates in the Atlantic County Medical Society grieve his sudden passing and adopt this resolution as testimony of our sincere sympathy and sorrow, and

Be It Further Resolved that this resolution be inscribed on the minutes of our Society and a copy be forwarded to his bereaved family.

The regular meeting of the *Medical Society of Atlantic County* was held at the Children's Seashore House on March 9. Vice-president, Dr. Baxter Timberlake, presided.

A motion picture entitled "Acute Abdominal Conditions," was exhibited. It showed patients with acute hemorrhage into the spleen and acute empyema of the gall bladder.

The business meeting was opened with the approval of the minutes of the previous meeting as published in the *Bulletin*. The application of Dr. Carl L. Kramer for associate membership was unanimously approved.

A resolution electing Dr. Benjamin L. Gordon to emeritus membership was unanimously approved.

Dr. Allman spoke on the position of the medical profession regarding Bill H.R. 7225. Then Dr. Gleason reported on the decision of the Committee with respect to the resolution submitted at the February meeting, concerning medical services incorporated in the Blue Cross Hospital Plan. The committee said that they approve the resolution in spirit and look forward to the eventual separa-

tion of the professional services of physicans from those non-professional services which more properly are within the jurisdiction of hospital administration. "We fully recognize radiology, pathology, anesthesiology, electrocardiography, and physiotherapy as medical services. We deplore the exploitation of the services of any physician by any hospital or organized lay group. While all this be true, we feel the ultimate implementations of such a motion is fraught with many administrative difficulties. We sincerely fear the possibility of disruption of existing medical services within our hospitals until such time as a practical application of such a motion can be clarified."

It was recommended by the Committee, and agreed by the Society, to lay the proposal on the table.

LEONARD B. ERBER, M.D.

Reporter

Bergen

A regular meeting of the *Bergen County Medical Society* was held on March 13 at Bergen Pines Hospital, Paramus. Elected to membership were: To Regular from Associate, Norman A. Bergman and Robert S. Frankel; To Regular from Courtesy, H. Preston Price; To Regular by Transfer, Lawrence Batlan, and Lucian Massarelli; To Emeritus Membership, W. S. Kilts, Romola Lyons, Howard M. Myer and Arthur A. Scullion; Leave of Absence to Ranald MacDonald for military service; Reinstatement from Emeritus, Marie J. Singer; Reinstatement on Return from Service, Jacob J. Vargish.

A Resolution on the death of Harry H. Pettit, a member of this Society for 36 years was unanimously passed.

Mr. William Granito, former Mayor of Hackensack and presently a member of the Bergen County Pharmaceutical Association urged the support of the Bergen County Medical Society towards the defeat of S-57.

Mr. William Upton, Executive Director of the Bergen Community Blood Bank delivered a report of its first year of operation.

The first reading of an amendment to our Constitution and several amendments to our By-Laws was read.

Delegates and Alternates to the Annual Meeting of The Medical Society of New Jersey for 1956-58, were elected.

Revised budget, necessitated by new and larger quarters for the office and additional personnel, was adopted.

A report on the meeting of the Sub-Committee on Public Health of the State Medical Society regarding the Salk vaccine program was received and discussed at considerable length.

A resolution regarding Blue Cross payments was adopted.

The regular meeting of the *Bergen County Medical Society* was held on April 10, at Bergen Pines, John E. McWhorter, President, presiding.

Dr. Dorothy P. Moore was elected a regular member after serving twelve months as an associate. Dr. Harvey J. Hatchfield was elected a regular member by transfer from Medical Society of the County of New York.

The proposed amendment to create the office of Assistant Treasurer was read for the second time. On motion regularly made, seconded and passed, the society went on record as disapproving Senate Bill S-57.

After a brief discussion, the following resolution on the definition of medical indigency was adopted.

> Whereas, it is the desire of the Bergen County Medical Society to limit the meaning of "medical indigency."
>
> It Is Resolved, that a person shall be regarded as not medically indigent if, (1) He, or another legally responsible therefor, is financially able to pay fees for physician's services rendered, or if (2) He has applicable health and/or accident insurance, or if (3) Such person has a claim against a person, firm or corporation for the payment of services rendered by a physician.
>
> It Is Further Resolved, that if an individual is deemed not medically indigent as indicated in the foregoing, any and all fees due for physician's services performed shall be paid to the doctor who has performed this service, or is responsible for its performance, or his authorized agent, and not to any institution or corporation.

Mr. Edwin J. Holman of the Law Department of the American Medical Association was the speaker. He invited audience participation and a lively discussion ensued concerning the Jenkins-Keogh bill, the availability of hospital tissue committee reports as evidence in litigation, the value of close cooperation between members of the local bar associations and medical societies. Questions from the floor were also raised regarding *modus operandi* of the AMA and its efforts to reflect the views of the majority of its members.

JOHN R. WILLIAMS, M.D.

Reporter

Camden

The regular monthly meeting of the *Camden County Medical Society* was held on March 6. Dr. A. G. Pratt, President, called the meeting to order at 9 p.m.

Drs. Donald C. Adrian and Stanley J. Okulicz were introduced to the Society after signing the register and taking the oath of membership.

Dr. Henry B. Decker introduced the speaker of the evening, Dr. Henry Beerman, Chairman of Dermatology, Graduate School, University of Pennsylvania. Dr. Beerman gave a very concise

and interesting talk on "Dermatology and General Practice" which he illustrated with excellent colored slides.

Dr. Robert N. Bowen presented a memoir on the passing of Dr. John I. Horner. The memoir was made a part of the permanent records of the Society and a copy was forwarded to Mrs. Horner.

Dr. Max Weimann reported that poliomyelitis vaccine is now available to indigent patients in all Camden County hospitals.

Reporting for the Executive Committee, Dr. Harold D. Barnshaw discussed the employment of doctors of medicine, rather than osteopaths as school physicians and health officers. He moved—and the society agreed that the membership be polled as to their willingness to accept such appointments.

The President announced that the two beautiful show cases now in the meeting room were the gift of the Auxiliary. The Secretary was instructed to write to the Auxiliary expressing the genuine thanks of the Society for this lovely gift.

Being "Hospital Night," the April 3 meeting of the Society was held at West Jersey Hospital. The President, Dr. A. G. Pratt, called the meeting to order at 9:15 p.m. Dr. Elliott C. Shull, president of the staff of the West Jersey Hospital, welcomed the Society on behalf of the Managers and the staff.

Dr. Edward LaVoice was introduced to the Society after signing the register and taking the oath of membership.

Dr. Earl B. Keller, Chairman of the Program Committee introduced the participants in the program. Dr. Charles J. Breme presented a case of pulmonary hypertension. Dr. Edwin A. Gleason discussed congestive splenomegaly and Drs. Edgar T. Gibson and Ellwood S. Paisley presented three diagnostic problems of the chest. The cases were all thoroughly prepared and were well received.

Notes from Drs. Walter Crist and James Eynon thanking the Society for flowers sent during their hospitalization were read.

The Secretary advised the Chairmen of the various committees of the necessity of sending in their annual reports by April 9 for inclusion in the *Bulletin*.

Following adjournment the members were invited to partake of a savory collation in the usual tradition.

FREDERICK W. DURHAM, M.D.

Reporter

Cumberland

The regular April meeting of the *Cumberland County Medical Society* was held at Richards Farm, Rainbow Lake, on April 10. Dr. Nicholas E. Marchione presided.

Dr. Albert B. Kump submitted resolutions to be permanently entered into the Society's minutes in remembrance of the late Drs. Charles W. Wilson and Fred D. Snyder, Jr. Dr. Earl C. Lyon likewise submitted a resolution in memory of Dr. Herbert H. Wilson. All three resolutions were unanimously adopted. The passing of these three physicians constitutes a great loss to our community.

Dr. Sherman Garrison, Jr. spoke briefly on Medical Education Week and announced a proposed program of five radio talks on the subject.

Dr. Benjamin Berkowitz urged members to accept the invitation of the Cumberland County Pharmaceutical Association to be their guests at a joint dinner meeting.

The annual election of officers resulted in the following selections:

President—Sherman Garrison, Jr., M.D.; President-Elect—Paul K. Ayars, M.D.; Treasurer—Samuel B. Pole, III, M.D.; Secretary—Mary Bacon, M.D.; Executive Committee (1 year)—Benjamin Berkowitz, M.D., Anthony E. Chmelewski, M.D. and M. David Baxter, M.D.; Reporter — Leonard G. Scott, M.D.; Delegates to Medical Society of New Jersey—Nicholas E. Marchione, M.D., Alfred O. Davies, M.D., H. B. Walker, M.D., Carl N. Ware, M.D., and Sherman Garrison, Jr., M.D.; Alternate Delegates to Medical Society of New Jersey—Kenneth Corson, M.D., Sidney L. Siegel, M.D., Frank J. T. Aitken, M.D., Benjamin Berkowitz, M.D.; Nominating Delegate to Medical Society of New Jersey—Carl N. Ware, M.D.; Alternate — Mary Bacon, M.D.; County Judicial Committee—Harry A. Reinhart, M.D., Sidney L. Siegel, M.D., and Charles Cunningham, M.D.; District Judicial Council—Maurice N. Harris, M.D.

Dr. Marvin N. Solomon, pathologist to the Newcomb Hospital in Vineland, spoke on forensic medicine. To complete his excellent presentation he enlisted the services of Mr. Alexander Jasko, a State Police officer, who gave a meticulous demonstration of the Harger "Drunkometer."

PAUL K. AYARS, M.D.

Reporter

Gloucester

An interesting presentation by Dr. Marie A. Sena on Civil Defense high-lighted the regular monthly meeting of the *Gloucester County Medical Society* which was held on Thursday evening, March 15, at the Woodbury Country Club. After the President, Dr. William Beall, called the meeting to order, Dr. Sena gave the Society an interesting presentation on Civil Defense in New Jersey from the state, county, and local level. Dr. Sena is Special Administrator of Civil Defense of the State Department of Health.

At the business session, considerable discussion was devoted to the Salk vaccine program. A news release by Dr. Weigele was read. The Society passed a resolution to send a letter of appreciation to him for this type of public release in answer to

criticism of the State Society and then passed a resolution approving in principle the establishment of a diagnostic heart clinic by the Gloucester County Heart Association.

Dr. Margaret Gerhart of Mantua was elected to Honorary Membership in the Society.

The regular meeting of the *Gloucester County Medical Society* was held at the Woodbury Country Club on April 24. Speaker of the evening was Dr. Daniel Downing, Pediatric Cardiologist at the Hahnemann Medical School. His excellent presentation was entitled "The office diagnosis of congenital heart disease."

At the business meeting, the members sadly received the news of the death of Dr. Gerhart of Mantua. A letter was read from the local Red Cross chapter concerning participation in the local Red Cross donation of blood. The Society reaffirmed its support, but suggested the Red Cross notify them early enough so that schedules might be rearranged to permit physicians to participate without undue inconvenience

Considerable discussion developed about the annual PTA "Summer Round-Up" of pre-school children for physical examination. These examinations are not connected with the Board of Education. Remuneration for these examinations is not a function of the School Board. It was recommended by the Society that in the future these pre-school examinations be done where possible in the private physician's office, and the school doctors not be burdened with extra work.

ROGER D. LOVELACE, M.D.

Reporter

Hudson

With Dr. Sigmund C. Braunstein presiding, *Hudson County Medical Society* held its regular monthly meeting at the Jersey City Medical Center, on March 6.

For the Nominating Committee, Dr. Gorenberg presented the list of nominees for office, elective committees, *et cetera*, for the coming administrative year.

The following resolution pertaining to transfer of certain benefits from the Blue Cross Subscription Contract to that of Blue Shield, was adopted: (It was offered by Dr. Silvera, president of the Radiologic Society of New Jersey.)

Whereas, it is evident that payments of certain medical services are now incorporated in Blue Cross Hospitalization Plan of New Jersey contracts for direct payment to the subscribing hospitals, and

Whereas, this concept is foreign not only to our ethical principles, but also to those of the American Medical Association,

Be It Resolved, that the Hudson County Medical Society go on record as requesting the deletion of such payments for medical services from the Blue Cross Hospitalization Plan of New Jersey and deletion of any other statement in the Blue Cross contract implying coverage of medical services; and that such medical services be included in the Blue Shield Medical-Surgical Plan of New Jersey.

Be It Further Resolved, that a copy of this resolution be sent to The Medical Society of New Jersey for appropriate action.

Dr. Braunstein made the following two announcements:

1. A testimonial dinner in honor of Dr. Ellis J. Chapman of Jersey City, a past president of Hudson County Medical Society, is being arranged by the Greenville Hospital Medical Staff.

2. The Annual Meeting of the American College of Surgeons will be held at the Medical Center on March 10, 1956.

As guest speaker, Dr. Solomon Silver, Chief of the Thyroid Clinic of Mt. Sinai Hospital, discussed "Modern Concepts of Thyroid Disease." Drs. Frank Bortone, Max Finkelstein, Nathan Frank, A. J. Gitlitz, Ethel Lawner, Morvyth McQueen-Williams, Harry Perlberg, Jr., and Harry Schneider — participated in a discussion from the floor.

Under the chairmanship of the president, Dr. Sigmund C. Braunstein, *Hudson County Medical Society* met in regular session on April 3 at Jersey City Medical Center.

Referring to a news item in the March 8, 1956 New York *Herald-Tribune*, Dr. Louis Kosminsky criticized Dr. Kenneth B. Babcock of the Joint Commission on Accreditation, for having publicly flayed one-quarter of the hospitals in the United States. In Dr. Kosminsky's opinion, information divulged by Dr. Babcock at a meeting of the United Hospital Fund should have been given to the agency concerned only, not to the public. Following discussion, a motion was made and carried that the newspaper clipping be sent to the American Medical Association and The Medical Society of New Jersey for their information, and with a request for appropriate action.

Elected to active membership were Dr. Benjamin B. Kaplan of Jersey City; Dr. Morris Kramer of West New York; and Dr. John W. McDonald of North Bergen.

Dr. Braunstein introduced Dr. Charles L. Brown, dean of Seton Hall College of Medicine, who was elected to active membership on January 3, 1956. (Dr. Brown is a former member of the Philadelphia County Medical Society.)

Guest speaker was Dr. George L. Kauer, Assistant Professor of Medicine at Cornell Medical College. Dr. Kauer discussed "Methods of Avoiding Common Hematologic Errors." Drs. Brown, Landshof, Rubenstein, and Yager participated in a subsequent discussion from the floor.

A collation was served after the meeting.

CHARLES A. LANDSHOF, M.D.

Reporter

Middlesex

The March meeting of the *Middlesex County Medical Society* at Roosevelt Hospital, Metuchen, was called to order by the President, Dr. Joseph F. Sandella. The minutes of the February meeting were read and accepted without addition or correction.

Committee report of Dr. B. F. Slobodien, Chairman of the Judicial Medical Ethics Committee recommended the following applicants for membership:

To two-year period of associate membership, Dr. Kenneth S. Gould, New Brunswick.

To regular membership on transfer from Union County Medical Society, Dr. Edward F. Balsbaugh, Du Pont's Photo Products Medical Division, Parlin.

These doctors were duly elected to respective membership by vote of the Society.

The scientific session followed. A very down-to-earth and novel approach to the "Rationale Therapy of Duodenal Ulcer" by Dr. Thomas P. Almy, Director of the Second Medical Division of Bellevue Hospital, and Associate Professor of Medicine at Cornell Medical College.

Committee reports included a report by Dr. S. Gurshman, Chairman of the Medical-Surgical Plan Committee, of the problems discussed by his committee, *i.e.* Drs. Matflerd and Fishkoff.

Dr. Gurshman requested and received authority to present recommendations to the Medical-Surgical Plan of New Jersey during the Annual Meeting in Atlantic City.

A letter was read from the State Pharmaceutical Society, requesting that the Middlesex County Medical Society endorse their opposition to S-57, permitting the unregulated retail sale of drugs by stores other than pharmacies. The Society supports the amendment proposed to control medicines sold through other channels. The Middlesex County Medical Society voted to endorse the State Pharmaceutical Society's request.

The Middlesex County Epilepsy League requests the support of the Middlesex County Medical Society and this was granted.

Dr. Gessner proposed a revision of the By-Laws as follows:

> That a member may seek and maintain Associate Membership status at any time and for a period longer than the proscribed two years as now defined. However, the member will be required to live and practice medicine in the county two years before transfer to regular membership.

Dr. Gessner requested the Constitution and By-Laws Committee be instructed to meet at their earliest convenience for a discussion of this problem. Dr. Slobodien amended the request to preclude the probability of disparity with the present Constitution and By-Laws.

On April 18, 1956, the regular meeting of the *Middlesex County Medical Society* was held at Roosevelt Hospital in Metuchen.

Dr. Benjamin Copleman introduced a resolution for acceptance by the Middlesex County Medical Society as follows:

> Whereas, it is evident that payments of certain medical services are now incorporated in Hospital Plan of New Jersey contracts for direct payment to the subscribing hospitals, and
>
> Whereas, this concept is foreign not only to our ethical principles, but also to those of the American Medical Association, therefore
>
> Be It Resolved, that the Middlesex County Medical Society demand the deletion of such payments for medical services from the Blue Cross Plan of New Jersey and any other statement in the Blue Cross contract implying coverage of medical services; and that such services be included in the Blue Shield Medical-Surgical Plan of New Jersey, and
>
> Be It Further Resolved that a copy of this resolution be sent to The Medical Society of New Jersey for appropriate action.

Dr. Sandella read the recommendation of the State Welfare Committee relative to the same idea. A motion was then proposed by Dr. Sokoloff "that the Middlesex County Medical Society endorse the resolution." The motion was carried.

Dr. B. F. Slobodien, Chairman of the Judicial Medical Ethics Committee, presented the following applications for membership: To regular membership, by transfer from the Anne Arundel (Md.) Medical Society, Baltimore, Md. Henry F. Zangara, M.D., New Brunswick. To two-year period of associate membership: Francis M. Clarke, Jr., New Brunswick; William Pollen, Perth Amboy. By vote of the Society membership was granted these applicants.

The guest speaker of the evening was then introduced by Dr. Reitman. Dr. Victor F. Marshall, Professor of Urology at Cornell, spoke on "Pyuria in Infancy and Childhood." The paper was well illustrated with lantern slides.

Dr. B. F. Slobodien, Chairman of the 1956 Nominating Committee presented the following slate for 1956-57:

> President—Sydney D. Becker, M.D.
> Vice-President—Gerard R. Gessner, M.D.
> Secretary—Reuben Levenson, M.D.
> Treasurer—George J. Kohut, M.D.
> Reporter—Morton M. Klein, M.D.

ALFRED J. BARBANO, M.D.
Reporter

Monmouth

Fort Monmouth was host to the *Monmouth County Medical Society* at its regular monthly meeting held at the Army Hospital on April 25. Dr. George McDonnell presided in the absence of the president.

Major General Victor A. Conrad, Commander, Fort Monmouth, welcomed the members. Colonel Rollin L. Bauchspies, Post Surgeon, discussed

"Medical Service at Fort Monmouth" and outlined the plans for the new post hospital. Dr. Frank B. Berry, Assistant Secretary of Defense (Health and Medicine), spoke on the "Medical Problems in Economic Mobilization." He stressed the need for medicine to keep abreast of technologic advances. Major General James P. Cooney, Deputy Surgeon General, Department of the Army, briefed the Society on the "fall-out problem" with reference to nuclear weapons. He pointed to the need for good organization, education and supervision to be prepared to cope with such a great catastrophy.

During the business meeting, the following were elected to full membership: Drs. George T. Hoffman and Merritt E. London of Red Bank. Dr. Ann Gosling, Fair Haven, was elected to associate membership.

All present enjoyed the gracious hospitality of the Medical Staff of Fort Monmouth, the interesting speakers and the delicious buffet dinner.

DONALD W. BOWNE, M.D.

Reporter

Morris

The *Morris County Medical Society* held its regular meeting March 15 at Warner Chilcott Auditorium in Morris Plains. Speaker of the evening was Dr. Henry B. Decker, Clinical Professor of Dermatology, Jefferson Medical School; Past President of The Medical Society of New Jersey. Dr. Decker discussed dermatologic problems in office practice. His paper was practical and was enjoyed greatly by the members of the society.

Changes in constitution and by-laws were brought forth and after much discussion the changes were accepted as of March 15, 1956.

There was some discussion of the problem of radiologists' fees and the Society decided not to take any action until further information was obtained.

The Society voted to participate in the national program for Medical Education Week and appropriated a sum of money necessary for such participation not to exceed a total of three hundred dollars.

The *Morris County Medical Society* held its scheduled meeting on April 18 at the Scientific Assembly Auditorium of the Warner-Chilcott plant in Morris Plains. There was discussion of possible society participation in the Medical-Surgical Plan. The scientific program was opened by the President, who asked your reporter to introduce the speaker. The essayist of the evening, Dr. Henry A. Davidson, is the author of the standard text, *Forensic Psychiatry*. Dr. Davidson spoke on the evaluation of disability in head injury.

ALBERT ABRAHAM, M.D.

Reporter

Passaic

The regular monthly meeting of the *Passaic County Medical Society* was held on Tuesday, March 20 at the Medical Society Building. Dr. Joseph R. Jehl, the President, presided.

The following physicians were elected to active membership: Drs. Joseph M. Gortych and Richard Rosendale of Wayne Township; Arthur L. Silverstein of Passaic. Dr. Gerald W. Vogel of Passaic was elected to associate membership.

Delegates and Alternates to the Annual Meeting of The Medical Society of New Jersey were elected.

The President informed the members that this Society will reserve an official meeting room where its members may enjoy their free time, during the Annual Meeting at Atlantic City.

Dr. Jehl spoke of the major changes of the Medical-Surgical Plan of New Jersey, in the new Series 1956 Subscription Contract. A lengthy discussion with many questions on this subject followed.

A communication from The Clinic for Mental Health Services was read. The Clinic's treatment program for the use of tranquilizing drugs in selected cases, was outlined.

Dr. Jehl told the members that the Rheumatic Fever Prevention Program was not sufficiently examined, and although the program was accepted at a meeting on December 13, 1955 by the membership, he felt there was not sufficient representation of members present at the meeting and the program is not ready for any definite action.

The President then turned the meeting over to Dr. Michael R. Ramundo who introduced the speaker, J. Maxwell Chamberlain, M.D., Attending Thoracic Surgeon, Roosevelt Hospital. Dr. Chamberlain's topic was "Advances in Cardio-Pulmonary Surgery," which he illustrated with colored films. A question period followed which seemed to be continued during the social period.

DAVID B. LEVINE, M.D.

Reporter

N. J. Chapter of A. C. S.

At its Annual Meeting, April 10, 1956, the New Jersey Chapter, American College of Surgeons elected Dr. James Spencer of Newton as president of the chapter. Dr. Ralph Belford of Princeton became vice-president, Dr. J. H. MacArt of South Orange was elected treasurer. The undersigned was elected secretary.

Doctors Samuel A. Cosgrove, Andrew McBride and Edward N. Sprague became the "Governors" of the chapter. The newly elected councillors are Doctors Samuel J. Lloyd of Trenton, George Stamps of Atlantic City and Harrison Wesson of Montclair.

BENJAMIN DAVERSA, M.D.

Secretary

Woman's Auxiliary • • •

Meet Kathleen Sauerbrunn

New Jersey must surely be the only state in the union whose medical auxiliary president is a writer of gags. That's right: Kathleen Handley Sauerbrunn finds time to write gags for a nationally syndicated comic strip,[1] when she isn't swimming,[2] writing plays,[3] fooling around with photography, taking care of three lively daughters[4] or clipping poodles.[5] This somewhat astonishing battery of talents is a New Jersey native, one of the prides of Little Silver, in which town she was born in 1917. A graduate of Douglas College, she was a mathematics instructor in the public schools for three years. She married Bertram J. L. Sauerbrunn while he was interning in Elizabeth, but since this is her story, not his, we'll say no more about Dr. Sauerbrunn.[6]

Kathleen Sauerbrunn attracts organizations the way honey attracts flies. These are smart organizations and they know a good worker when they see one. She has been a church trustee and an officer of the Grand Jurors' Association. She has presided over our Union County Auxiliary and held a variety of posts in the State Auxiliary. She chaired the Woman's Guild at St. John's Episcopal Church in Elizabeth. She is a functionary in the Elizabethtown Dramatic Club and in the Elizabeth Town and Country Club.



She is also a faithful worker in the Mid-county Companion Dogs Obediance Training Association.

Isn't that enough? Meet Kathleen Handley Sauerbrunn!

Auxiliary Reports • • •

Camden

During 1955-56, our programs and places of meeting have been varied. We have met in the home of one of the members, in the Haddon Fortnightly Clubhouse, Haddonfield, at Our Lady of Lourdes Hospital, Camden, and at the Cherry Hill Inn in Delaware Township. Programs have included a talk by Miss Jane Stretch, editor of the Camden *Courier-Post* on housing and health problems in Camden County; an original Christmas entertainment by our own drama and music groups; an illustrated lecture by Dr. Samuel X. Radbill, of the University of Pennsylvania on "Medicine Through the Ages;" and musical entertainment by the Glee Club of Rutgers University.

1. For security reasons, the name of the comic strip cannot be here revealed.
2. She was the AAU New Jersey Free-style swimming champion for both 50 and 100 meters; she was an Olympic Team runner-up; and on the Newark Athletic Club's swimming team, too.
3. A writer of unproduced plays. Mrs. Sauerbrunn has just lost her amateur standing, since last month, her 1-act play was produced. Entitled "The Fruit," this was produced at the Elizabeth Town and Country Club.
4. Jennifer, Sharon and Randa.
5. She has four dogs, whom she personally clips whenever they need clipping. Three of these are genuine French poodles, while the other, a true All-American dog represents many strains.
6. No secret really. Dr. Sauerbrunn is an internist affiliated with all three hospitals in Elizabeth.

Our Nurse Recruitment Committee has spent an active year. Two new "Future Nurses' " Clubs were formed, bringing the total under our sponsorship to eight. Approximately 250 girls are participating in these clubs throughout the county, 100 of whom will receive pins for completion of 20 hours of hospital service.

Our Card Party and Fashion Show for the Nurse Scholarship Fund made a profit of $729 from which two scholarships have been awarded.

Our Public Relations Meeting on the theme "Periods of Readjustment" aroused keen public interest, resulting in a record attendance of 525. The problems of adolesence, the menopause, retirement, and old age were discussed by specialists in pediatrics, endocrinology, psychiatry, and geriatrics.

Our Mental Health Committee has given two parties for patients of the Camden County Mental Hospital, Lakeland, and contributed to the Christmas fund for indigent patients.

The Histories Committee of the Auxiliary has been working with the Medical Society Histories Committee in the preparation of an anniversary book commemorating the 110th year of the Society. A list has been compiled of the M.D.s in Camden County who have been licensed to practice since 1880. Biographies have been written for as many as possible. Auxiliary members have done most of the research and writing, as well as the typing of the material. The Arts Committee is designing a cover for the book.

The Auxiliary in April published the first issue of its own new quarterly *News Bulletin*.

On May 11, the Camden County Auxiliary sponsored a trip to the Henry Francis duPont Winterthur Museum, Winterthur, Delaware.

Two community health programs using the film, "Answering the Child's Why," have been given to PTA groups, with a psychiatrist participating in the program.

The American Medical Education Fund Committee has been active distributing literature, and presented a film, "Danger at the Source," at the Public Relations Meeting. Its appeal for funds is at present meeting with satisfactory success.

At the Annual Meeting and Luncheon May 1, Mrs. A. M. K. Maldeis, retiring President, installed the following new officers for 1956-57: Mrs. Leland M. Stetser, President; Mrs. Stanford P. T. Seto, President-Elect; Mrs. William J. Browning, II, First Vice-President; Mrs. George W. Hager, Jr., Second Vice-President; Mrs. Edward F. Mazur, Treasurer; Mrs. Wallace B. Hussong, Recording Secretary; and Mrs. Martin E. Swiecicki, Corresponding Secretary. Mrs. Maldeis and Mrs. David H. West were installed as Directors to serve for three years.

MRS. F. LELAND ROSE

Publicity Chairman

Essex

Public Relations Day was held by the *Essex Auxiliary* on March 7 at Graulich's auditorium in Orange. The topic, "Mental Health and Juvenile Delinquency," was discussed by an eminent panel of speakers with Dr. Harrold A. Murray, Past President of The Medical Society of New Jersey as moderator. The psychiatric viewpoint was presented by Dr. Lauretta Bender, Principal Research Scientist in Child Psychology for the Department of Mental Hygiene of the State of New York. The community viewpoint was presented by Mr. Charles W. Kappes, Associate Counsel for the Mutual Benefit Insurance Company. The legal viewpoint was discussed by Judge Harry W. Lindeman, Presiding Judge of Juvenile and Domestic Relations Court of Essex County.

Mrs. Ralph R. Autorino, President of the Auxiliary, and Dr. Jerome G. Kaufman, President of the Essex County Medical Society, welcomed the guests. The meeting was open to the public and 185 guests registered.

The philanthropic efforts of the Essex Auxiliary so far this year have been rewarding. "The Snow Ball," held in December for the benefit of Nurse Scholarships and other philanthropic projects, netted a total to date of $2,100 and should approximate $3,000 according to Mrs. William D. Miningham, Jr., chairman.

Proceeds raised as a result of a very successful Valentine's Day Bridge-Luncheon were over $800. The amount will be turned over to the American Medical Education Foundation for distribution among the nation's medical schools. After the luncheon, Mrs. Frank D. Bellucci, Chairman, introduced Mrs. Frank S. Forte, State Auxiliary Chairman of A.M.E.F., who explained the purposes of this project.

On February 27 Mrs. Ralph R. Autorino presided at the regular and board meetings held at Graulich's in Orange. Mrs. George Parell, Program chairman, introduced Mrs. Anna Rose Wright, noted author and lecturer, who was the speaker for the day. A film entitled *You and Civil Defense* was shown with Mrs. Anthony P. Caggiano, Civil Defense Chairman, in charge. After the meeting tea was served with Mrs. Michael J. Hyland and Mrs. Chester Modeski serving as hostesses.

Past-presidents of the Essex Auxiliary were honored at the meeting held on Monday, March 26, at Graulich's. After the business meeting conducted by Mrs. Ralph R. Autorino, President, a short history of the Essex Auxiliary was given by Mrs. Anthony Ambrose, chairman of the Archives Committee. The Society was organized 29 years ago on March 10, 1927 with fifty members. Since then it has grown to include 450 members in 1956.

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TUBERCULOSIS *Abstracts*

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ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXIX June, 1956 No. 6

TB, GERIATRIC PROBLEM

By John B. O'Connor, M.D., BULLETIN, NATIONAL TUBERCULOSIS ASSOCIATION, *January, 1956.*

The trend towards older patients in our tuberculosis hospitals raises many questions for which there are, as yet, no answers. If, however, the current trend continues, and there is no reason to suspect that it will not, the care and treatment of pulmonary tuberculosis will truly require the services of those experienced not only in tuberculosis but also in the management of the elderly individual.

Only 15 years ago the majority of patients in the tuberculosis hospitals were active, alert young people and the principal problem encountered was that of enforcing some degree of bed rest. At the present time, the majority of patients in tuberculosis hospitals are above the age of 40 years with over one-fifth being above the age of 60 years.

This change in patient age groups has resulted in a different, sometimes depressing, atmosphere in the hospitals. In addition, it has altered the whole medical routine because of the increased incidence of non-tuberculous complications seen in these older age groups. In many patients the tuberculosis seems a complication secondary to a major non-tuberculous condition.

Does this mean that pulmonary tuberculosis has now become a disease of older people? By no means is this true. The answer is that the excellent tuberculosis control work of the past has screened the younger age groups and removed the potential source cases before the disease can be spread, thus reducing the number of new cases among the younger ages. A weakness of the control program has been the lack of cooperation of the older people, many retired or unemployed and not accessible to industrial or group surveys. This is now being corrected by orienting case finding programs toward older age groups and by the routine chest films obtained on general hospital admissions. In our experience the latter source is responsible for the discovery of the majority of patients with tuberculosis in the older groups.

In Connecticut during the year 1938, 52 per cent of all tuberculosis hospital admissions were under age 30, and only *six per cent* were above 60 years of age. In 1953 only 23 per cent of the admissions were under age 30 and 22 *per cent* were above 60 years of age with the males predominating in a ratio of more than four to one. The total admissions of all age groups increased 50 per cent between the two periods but the group above 50 years of age increased about *370 per cent*. Although older men predominate it is significant that more older women are also being admitted.

The older age groups in Connecticut are a known reservoir of infection and make up a large part of our tuberculosis patient population. Where were these patients 15 years ago and what was the state of their health? Were they the infected cohorts with clinically inactive pulmonary disease of those who died of tuberculosis then? Did they succeed in escaping detection only to break down in later years?

This was once an accepted theory, but many of the current older patients have had normal chest x-rays during previous hospitalizations or have had previous survey films which were en-

tirely normal upon review. They have acquired or developed their disease for the first time in the later years of their lives. Years of routine chest x-ray surveying have made it possible to time the development of pulmonary tuberculosis in older age groups. This aspect of routine chest x-ray surveys and their value as a base line for other pulmonary conditions, such as carcinoma of the lung, have been of exceeding value to the physician in the study of pulmonary tuberculosis in the elderly patient.

The problem of treatment in these patients is made difficult by the frequent presence of emphysema, by complicating cardiovascular disease, and by the inability of many such patients to adjust to hospital life. Therefore it becomes imperative to discover and treat these patient while the disease is in its early stages.

Such methods as surveys of older age groups and routine chest films on all general hospital admissions have been mentioned. All diabetics should have chest films at the time of discovery and repeat films at least annually. Patients with chronic pulmonary complaints should not be dismissed with one normal chest x-ray. If symptoms persist repeat films are indicated. Chronic alcoholics should have frequent chest films since this group, comprised largely of social outcasts and homeless men, has an extremely high incidence of pulmonary tuberculosis. Routine surveys of nursing homes and old age homes will uncover patients with active disease. Age does not protect against active pulmonary tuberculosis. No age group can be considered immune.

Age is not a deterrent to recovery from pulmonary tuberculosis. An elderly patient with few degenerative changes should have no more difficulty in treatment than a younger patient. Such patients have undergone thoracic operations for resection of residual disease with minimal complications. Stability of disease has been achieved in some with prolonged medical treatment. Unfortunately, many of the older patients present themselves with extensive disease and are unable to tolerate any major operative procedures because of non-tuberculous complications.

With antimicrobial therapy and other measures the death rate from tuberculosis has declined dramatically in the younger age groups. In the older age groups stabilization of disease often occurs in patients in which complete recovery cannot be obtained, only to have the patient die of a non-tuberculous condition. Occasionally treatment, although arresting the active tuberculous process results in changes in the lungs which cause a greater work load for the heart and the patient dies in later years of heart failure. Thus, although these patients have had active tuberculosis, their death rate from tuberculosis has dropped and their death can be attributed to other causes.

It is estimated that by 1960, between 13 per cent and 15 per cent of the adult (over age 20) population of the United States will be 65 years of age or older. If these older people continue to be infected with the tubercle bacillus, as they are now, the problem of tuberculosis in this age group will persist and may become more acute.

The successful screening of younger people in the past should be the key to control of disease in the older age group. Admittedly, these elderly people are hard to reach. Education of this group must be pressed vigorously so that they will participate in x-ray surveys. Recovery with the aid of modern treatment must be emphasized in order to eliminate the passive attitude assumed by many elderly people.

Similarly, these older folk must learn that if tuberculosis is detected early they stand an excellent chance of recovery. The best way of finding their disease early is by annual chest x-rays. Perhaps if tuberculosis can be well controlled in this older age group another great step in eradication of the disease will have been taken.

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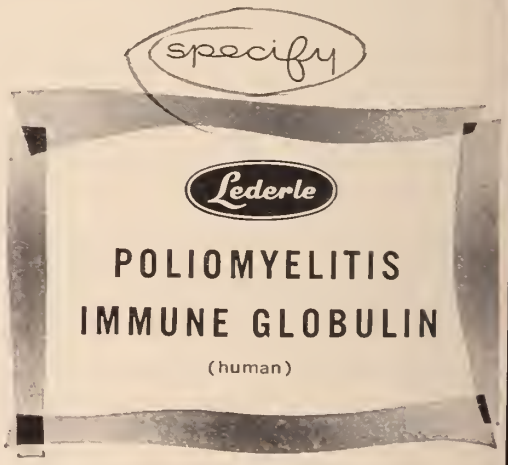
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1. Johnston, T. G., and Cazort, A. G.: J. Allergy 27:90, 1956. 2. Schwartz, E.: New York J. Med. 56:570, 1956. 3. Schiller, I. W., et al.: J. Allergy 27:96, 1956.

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*McLester, J. S., and Darby, W. J.: Nutrition and Diet in Health and Disease, ed. 6, Phila., Saunders, 1952, p. 195.

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*Fishberg, A. M.: Hypertension and Nephritis, ed. 5, Philadelphia, Lea & Febiger, 1954, pp. 177-178.

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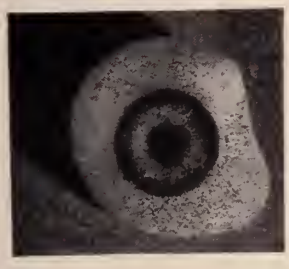
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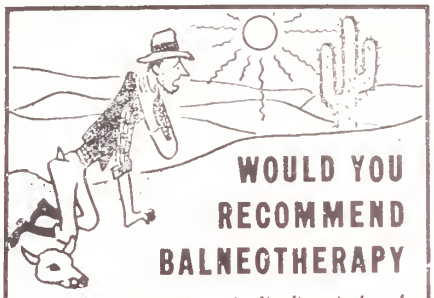
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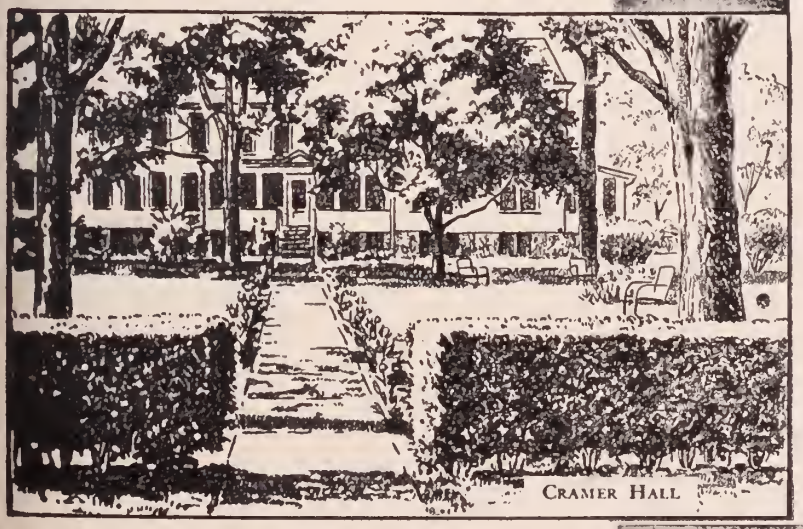
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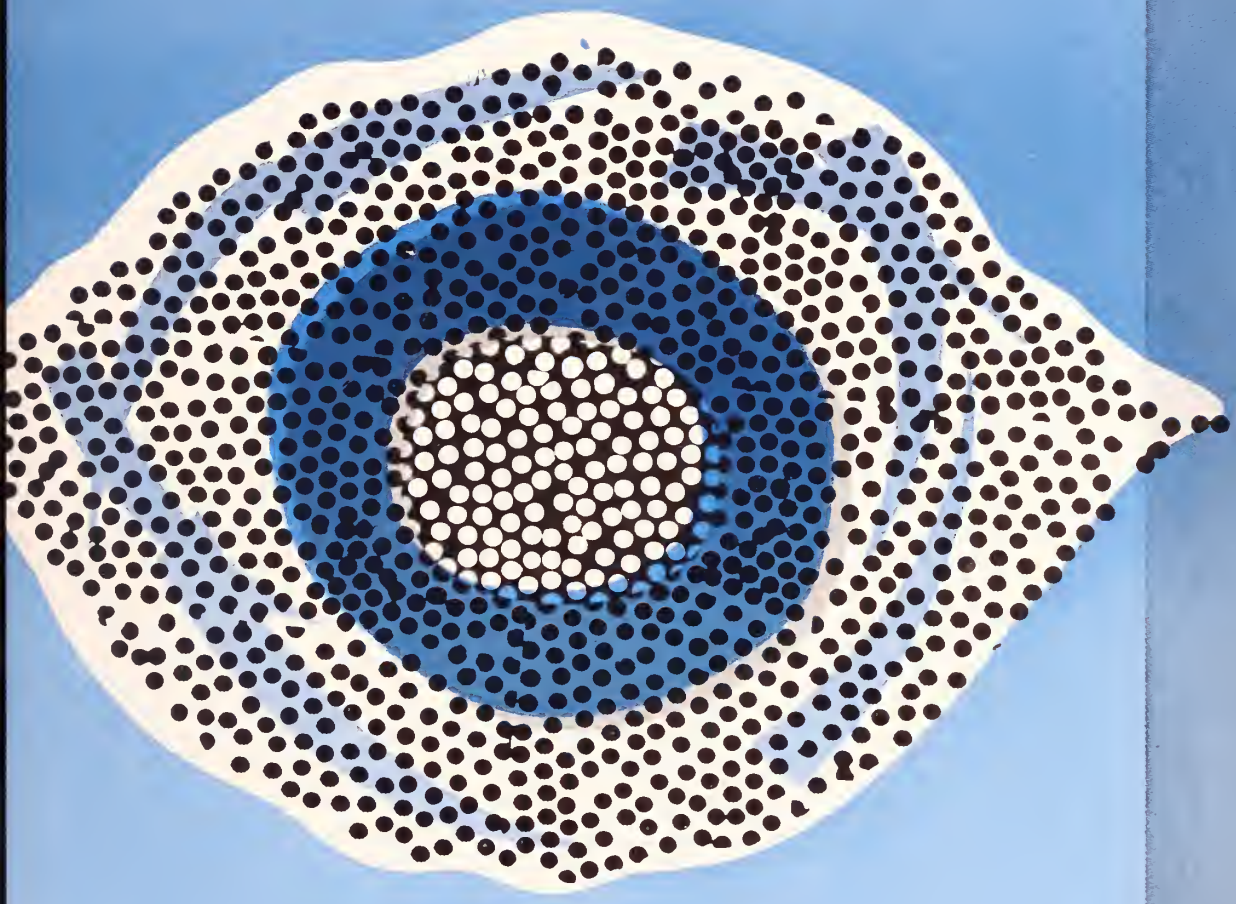
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Zephiran® Cl, 1:5000
wetting agent and antibacterial

DELIVERS FINE EVEN SPRAY
LEAKPROOF

Rapidly Effective
No Antibiotic Sensitization



Supplied in spray bottle containing 20 cc.

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Professional men who have studied the microscopic analysis of the Viceroy filter now know why the Viceroy taste is smoother—never rough. Only Viceroy has 20,000 tiny filters in every tip—twice as many filters as the other two largest-selling filter brands. That is why Viceroys are smoother by far—never, never rough. That is why so many doctors now smoke and recommend Viceroys.

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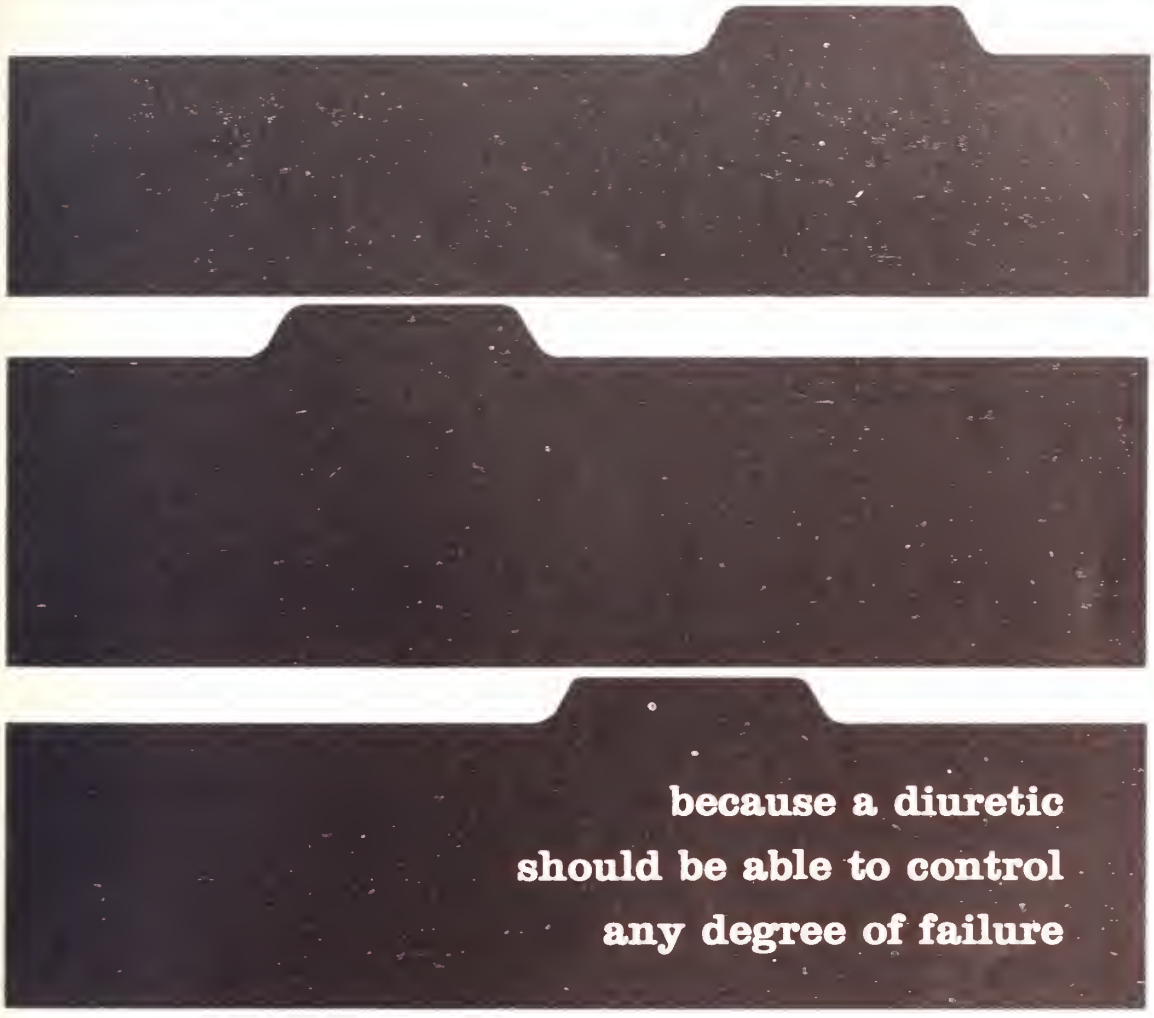
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a standard for initial control of severe failure

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Only meat is meat.

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

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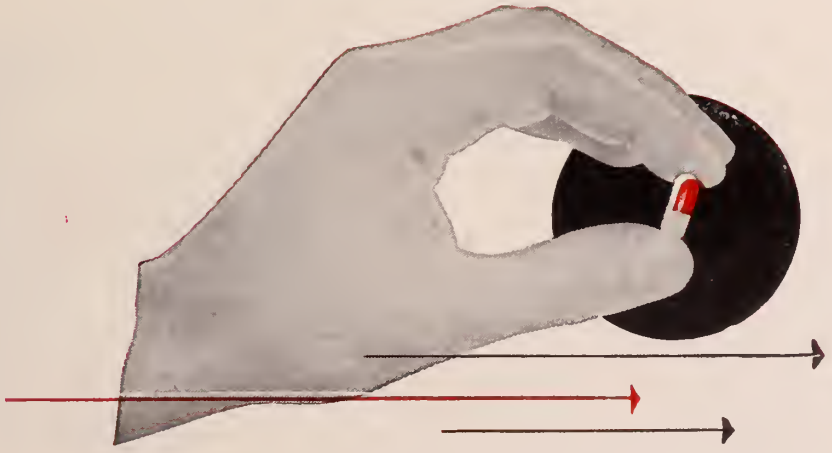
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RESISTANT TO ALL OTHER

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to overcome specific infections that do not respond to any other antibiotics.[1,2,3]

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ACTION—'CATHOMYCIN' in optimum concentration is bactericidal. Cross-resistance with other antibiotics has not been observed.[7]

TOLERANCE—'CATHOMYCIN' is generally well tolerated by patients.[5,6,8,9,10,11]

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(Crystalline Sodium Novobiocin, Merck) **SODIUM**

ABSORPTION—'CATHOMYCIN' is readily absorbed[5,6,9] and oral dosage produces significant blood and tissue levels which persist for at least 12 hours.[7]

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SUPPLIED: 'CATHOMYCIN' Sodium (Crystalline Sodium Novobiocin, Merck) in capsules of 250 mg., bottles of 16.

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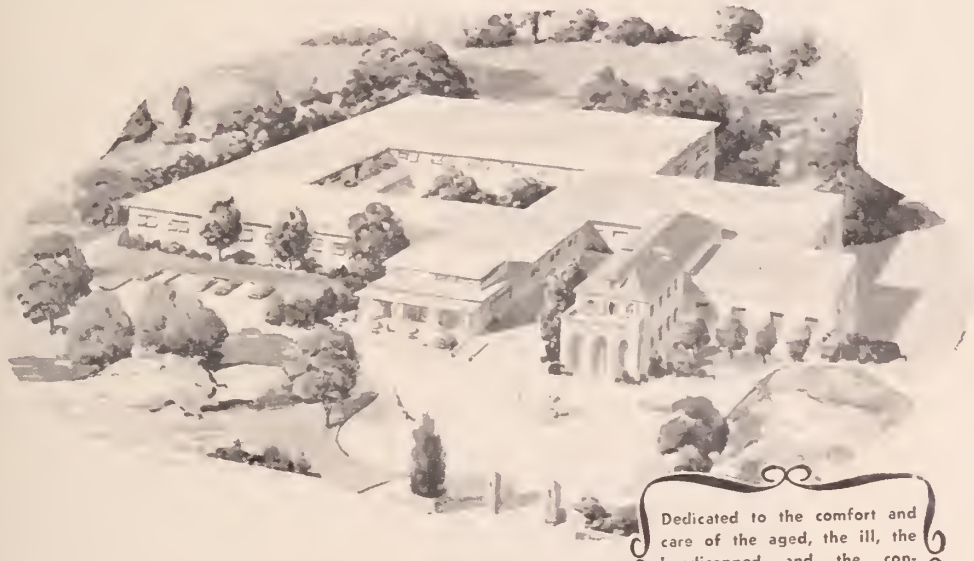
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References: 1. Hollander, J. L., *Ann. New York Acad. Sc.* **61**:511, May 27, 1955.
2. Hollander, J. L., *et al. J.A.M.A.* **158**:476, June 11, 1955.

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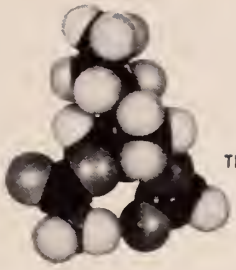
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- no blood dyscrasias, liver toxicity, Parkinson-like syndrome or nasal stuffiness
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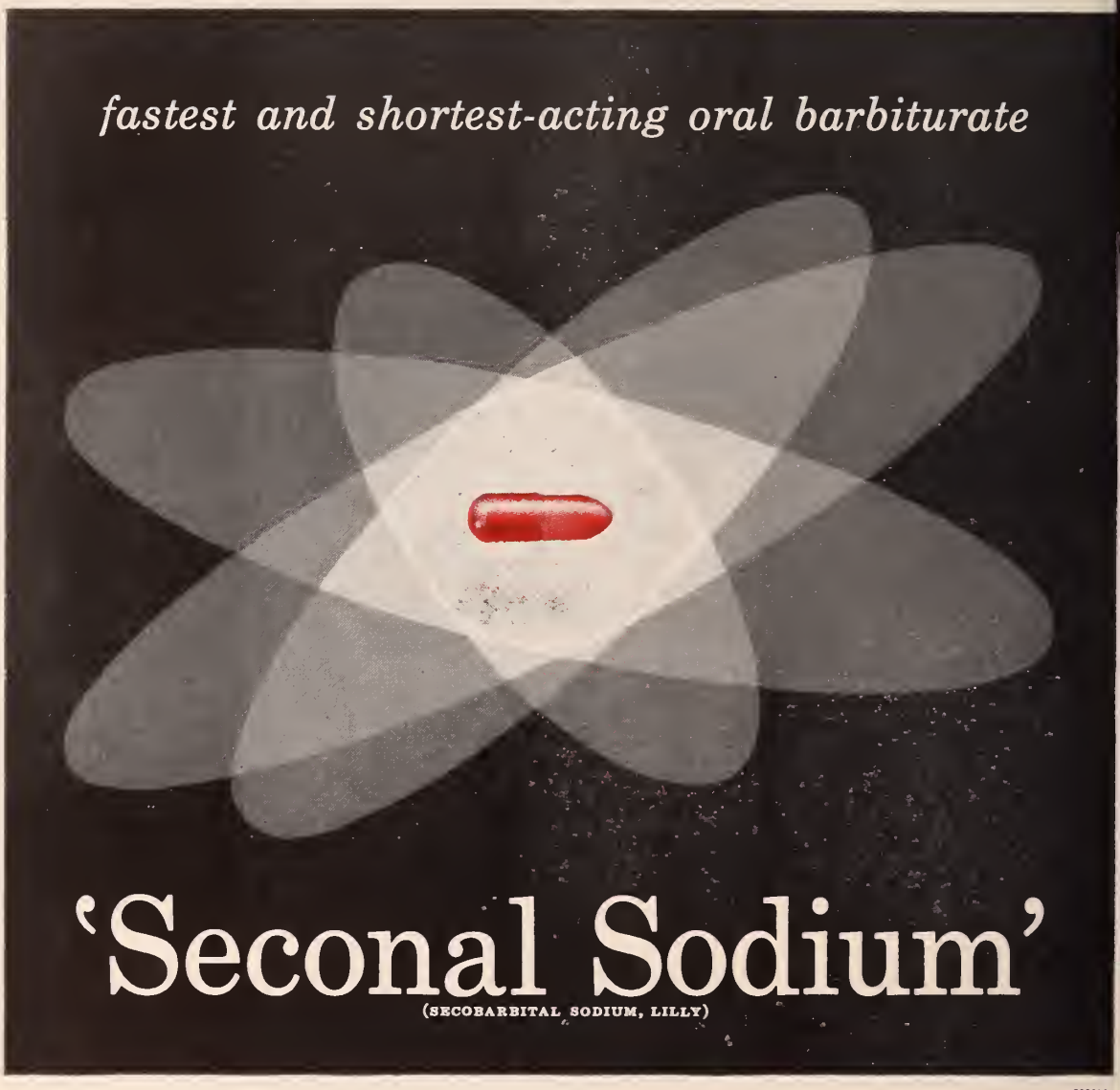
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Editorials • • •

Congratulations, A. M. A.!

For the first time in its history the American Medical Association will have a New Jersey physician as its President. The A.M.A. did itself this good turn when on June 14 it elected our David B. Allman President-Elect. The election was unanimous.

Although Dr. David B. Allman was born in Philadelphia, he has been a resident of our state since his return from the Navy and Public Health Service at the end of World War I. He has devoted much of his time to philanthropic and eleemosynary activities including, thirty-five years of pleasant service as official physician of the Miss America Pageant. His wife, Katherine, was President of the Woman's Auxiliary to the A.M.A. in 1950. This is probably the only time in A.M.A. history that a husband and wife team held both top positions in organized medicine.

The *Daily Bulletin* of the A.M.A. Convention has three or four columns listing in some detail the many organizations with which Dr. Allman is affiliated and the numerous extracurricular and professional activities which keep him busy. It is hardly necessary for us who know him so well to repeat the list here.

He is, of course, President of our State Board of Medical Examiners, and has for 10 years served as Chairman of the Finance and Budget Committee of The Medical Society of New Jersey.

As we in New Jersey know, and as the high command of the A.M.A. will soon find out, Dave Allman makes fast decisions which usually turn out to be sound ones. This is one of the qualities which make him a good administrator. This is one reason for the incessant demands for his service in so many other or-

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ganizations. He is also conspicuous for the firmness with which he carries out these decisions, for a complete unwillingness to compromise with right, and a repugnance at anything shoddy or second-rate. However, he wears no halo—or if he does, it is sometimes askew. He is no inhumanly efficient thinking machine. He has rather a warm and comfortable personality. When he was nominated last month, delegates from the four corners of the nation kept tripping over microphone cables in their wish to second the nomination.*

At this point the traditional thing to do is to congratulate Dave Allman. He probably needs our condolences instead. He is in for a hectic year. But what we will do is this: we congratulate the A.M.A.

*According to Robert's *Rules of Order* a nomination need not be seconded. But in their understandable desire to join the Allman bandwagon the delegates acclaimed him anyway.

Black Market Babies

It seems like a gratuitously harsh indictment, when they call a doctor a "baby peddler," or when they brand his well-intentioned adoption efforts as "black market racketeering." But it has become necessary for New Jersey, like most states, to put certain restrictions on adoptions. Elsewhere in this issue* we summarize the parts of the current statute of interest to physicians.

The business of finding a suitable home for a baby is a tricky one. You cannot depend on your hunches, instincts or sentiments. The fact that you have known the X family for years does not qualify you to state that they are proper adoptive parents. There are more subtleties in proper baby placement than there are in making a diagnosis of liver disease. Each calls for an expert. You may be an expert in liver disease. Concede that some one else is the expert in child placement. The approved social agency will not try to treat a cold or make a diagnosis. We should not try to make placements of children.

If a woman who has, or expects to have, a baby asks you how she can have it adopted out, refer her to an approved adoption agency.* If she asks you to suggest a couple who could give the baby a good home, explain that the law does not allow you to comply with her request. If a childless couple ask you to "get" a baby for them, tell them to communicate with a children's agency.* If they ask you to put them in touch with some pregnant but unmarried woman, shake your head gently from side to side, and refer them to an agency. You are committing a crime if, no matter how good your intentions, you furnish that information directly to the persons.

Let there be no mistake about this. The law is clear, blunt and unequivocal: "No person . . . shall place, offer to place, or *in any manner assist* in the placement of a child in the home of any other person for the purposes of adoption . . ." The italicized phrase, *in any manner* is broad enough to cover any hint you may give a mother about a prospective adopting couple. You may feel that this law is one more example of Government interposing itself between private individuals. You may feel that you are doing God's work in transferring a baby from a rejecting mother to a protective, baby-hungry couple; and you may even feel that punitive legislation like this puts one more land-mine in the way of the peaceful practice of medicine, adds one more hazard to one's daily work. However, casual placements, shoddy investigations, and peddling of babies are serious offenses. The world of tomorrow will belong to today's babies. No amount of care is too great in assuring that they get off to a good start. Perhaps they will do better with this world than their parents and grandparents.

*See page 386 of this JOURNAL.

Is a Hospital a Business?

Hospitals are expected to be business-like. They have to buy equipment and supplies, and in that market place must act like other businesses. If their expenses regularly exceed their income, they must, like other organizations, go out of business. They have public relations problems, personnel problems, and board-versus-management problems similar to those which affect industrial organizations.

But the differences outrank the similarities. A manufacturer of fire-extinguishers will not sell you his product no matter how badly you need it, if you can't pay for it. But a hospital does not shut its doors in the face of an acutely sick man or a desperately injured one on that basis. The industrial executive can be measured by profits. The greater the gap between income and expenses, the greater the accolade given the manager. If a business man can say that he operates on $4 per item *per diem*, whereas the average is $6, the business man gets a pat on the back. But a hospital administrator does not boast of a low *per diem* cost.

The key man in rendering service in a hospital is the physician. And except in certain special situations, he is not paid by the hospital. This makes the hospital unique in the business world. In other nonprofit organizations (schools for instance), there is the standard employer-employee status between management and the professional person rendering the key service. This establishes a very special relationship between staff and management in a hospital—as any one can see by comparing the teacher's attitude towards authority with the private practitioner's.

In business, the manager is usually a member—often an officer—of the Board. In business, as strong managers develop, the Boards become less influential. In hospitals, the administrator is an employee of the Board, hardly ever a member or officer in the usual sense. By reason of personality, some administrators of course are strong, and some Board personnel are weak. But the general pattern is to have a Board that definitely circumscribes the administrator's authority, at one end. The staff, in effect (if not in theory) circumscribes it at the other end. No industrial manager would last long—or want to last — under that arrangement.

A hospital dare not boast of profits, an industrial organization dare not boast of losses. The public will tolerate a strike of industrial employees, but never of hospital employees. Labor relations are thus something special in a hospital. The employees have none of the bargaining power that the strike weapon provides, though they may have acquired a power by reason of their scarcity. A business may have an occasional money-losing department as a sort of "loss leader," but this is exceptional. Every hospital has many money-losing departments, and it is often these very departments that give the hospital prestige. People often leave money to hospitals, seldom to businesses.

The hospital is more and more becoming an office for private practitioners. If this trend continues,* the hospital will also be in the landlord business and this will further complicate the picture. Under those conditions, will the hospital demand the special privileges (tax exemption, for instance) it enjoys because it is *not* a business?

Medicine is becoming more hospital-centered. Doctors have an increasing stake in hospital health. It is, perhaps, natural to think of a hospital as a business—as a sort of hotel for sick people. But it behooves us to see that in a larger sense, whether we like it or not—indeed, whether *they* like it or not the hospital is not *a* business. It is your business — mine—and everybody's.

*See, for example, the article on page 109 of the April 1956 *Medical Economics*.

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Asbury Park

The Decreasing Mortality From Perforated Peptic Ulcer*

In 1933, a person with a ruptured peptic ulcer had a 50-50 chance of survival. Today, the death rate is only 5 per cent. Dr. Guthorn, in this unique study, appraises the factors which have accounted for this gratifying improvement.

PERFORATION is the most common fatal complication of peptic ulcer occurring in an estimated 10 per cent of cases. Primary purpose of this study is to examine the influence of sulfonamides, antibiotics, gastric suction, blood transfusion, parenteral fluids, and intraperitoneal drainage upon morbidity and mortality. A secondary purpose is to examine the change in attitude toward the use of gastric suction, parenteral fluids and intraperitoneal drainage during the period covered by this study.

From 1933 to 1952, inclusive, 165 cases of perforated peptic ulcer were treated at the Monmouth Memorial Hospital. The 149 operative cases have been divided into four groups on the basis of antibiotic or sulfonamide therapy.

I NO SULFONAMIDES OR ANTIBIOTICS

THIS group consists of one woman (age 66) and 44 men. Most of them were admitted prior to 1946, though a few entered as recently as 1951. Ages ranged between 24 and 75, with an average age of 49½. Previous ulcer history was given by 35 patients: in 17, the history was of less than five years' duration and in six patients there was no antecedent ulcer history. There had been a previous perforation in one patient only. This had occurred two years before. In one case, a duodenal perforation, there had been a previous gastroenterostomy eight years before and a gastrojejunal fistulectomy five years before. In three cases, perforation occurred while hospitalized. Two of these almost immediately followed upper gastrointestinal x-ray studies. Gastrointestinal bleeding was a prominent factor in three patients. In five patients abdominal x-rays were taken, pneumoperitoneum being evident in two. A correct pre-operative diagnosis was made in 39 patients. The common mistaken diagnoses were appendicitis and cholecystitis.

Duration of perforation before surgery was 10 hours in the surviving patients as against 42 hours in those who succumbed. Average age of survivors was 45½ years as opposed to 54 years for those who died. Site of perforation was gastric in 32, duodenal in seven, and pyloric in three. Site of perforation was not found in three cases. A single instance of

*Read May 14, 1956, before the Section on Surgery at the Annual Meeting of The Medical Society of New Jersey.

double perforation of the duodenum was found.

The most frequent incision was an upper left rectus muscle-splitting approach. In a smaller number, left paramedian, right paramedian, right rectus and right pararectus incisions were used. A lower right rectus appendectomy incision was extended upward to permit closure of a gastric ulcer in one instance. In another case, appendectomy *via* a McBurney incision was followed by a right paramedian incision for closure of a duodenal perforation. The operative treatment was transverse suture plication of all perforations with heavy chromic catgut reinforced by omental tabs. In the case of a perforation of 28 hours, the gastric ulcer was found already sealed and no attempt at closure was made. Cholecystostomy with removal of a solitary large calculus followed plication of a gastric perforation in one case.

PRIMARY partial gastrectomy was done on a patient who had suffered previous repeated hemorrhage. Closure of the peritoneum and posterior sheath was by a continuous heavy chromic catgut suture. The anterior sheath was similarly closed. In almost all cases, this was reinforced by multiple heavy silk retention sutures through skin and anterior sheath. Continuous suction by a nasogastric tube was used in 14 cases. No tube or suction was used in the remainder.

Blood transfusion was administered to five patients and parenteral fluids to 33 patients. In a substantial number, the parenteral fluids consisted of 3,000 cubic centimeters of normal saline daily for five to six days. In the later years of this study, parenteral fluids tended to be given more in relation to the patient's needs. In seven of the 33 cases the fluids were administered by hypodermoclysis. In six other cases small repeated proctoclyses were given.

Multiple intraperitoneal drains were used in six cases. Commonly, a heavy wall rubber tube inserted through a suprapubic stab wound was used in conjunction with multiple rubber tissue drains inserted over and under the liver through subcostal stab wounds. In eleven cases a single rubber tissue intraperitoneal drain through the operative site plus a subcutaneous drain were used. In 16 patients the subcutaneous tissue only was drained, and in eight cases no drainage at all was used.

There were 15 non-fatal complications in ten patients, including five wound infections, two cases of atelectasis, two of persistent singultus and two of persistent postoperative gastrointestinal bleeding. Average hospitalization was 18 days. There were 20 fatalities, giving a mortality rate of 44 per cent. Fatal complications were peritonitis in 12 cases, subphrenic abscess in five, persistent gastrointestinal bleeding in three, pneumonia in two, empyema in two; and gastric fistula, pulmonary edema, pleural effusion, and shock in one case each. Survival following operation varied from 2 to 74 days, with an average of 16 days.

II. SULFONAMIDES ONLY

TWENTY-EIGHT patients received sulfonamides only. The majority received parenteral Prontosil®, sodium sulfanilamide or sulfadiazine. Many were given intraperitoneal sulfanilamide in doses of 5 to 10 grams at operation. A few received intraperitoneal sulfanilamide only. The years covered were 1938 to 1945. Average age was 49½ years. All were male with one exception. A previous ulcer history was given in 22 cases. One patient had had a previous perforation. Three perforations occurred while patients were hospitalized. Gastrointestinal bleeding was noted in one case only. Abdominal x-rays were taken in four cases and revealed pneumoperitoneum in three. Site of perforation in 15 cases was gastric, pyloric in two, and duodenal in seven. Site of perforation was not established in four cases. Average duration of perforation was 11 hours in the survivors, and 22 hours in those who died. Average age of survivors was 47, compared with 59½ for those who died. The correct pre-operative diagnosis was made in 24 cases.

The surgical treatment was substantially the same as in the previous group. In two cases, appendectomy preceded closure of the ulcer. In one case a primary partial gastrec-

tomy was performed on a patient in whom perforation occurred while he was being prepared for a partial gastrectomy. Severe gastrointestinal bleeding occurred in this patient previously and at the time of perforation.

Nasogastric suction was used in 11 patients postoperatively. Six patients received blood transfusions, 27 received intravenous fluids, five received fluids by clysis, and two patients by proctocylsis. In only one case was parenteral fluid not administered.

In eight patients wounds were closed without drainage and in nine the subcutaneous tissue only was drained. Intraperitoneal drains were used in eight cases and multiple drains in one case only.

There were eight non-fatal complications in six patients. These were wound infections in three, ileus in two; and wound dehiscence, pleural effusion, and subphrenic abscess in one each. The subphrenic abscess was drained surgically without sequelae.

There were five deaths, a mortality of 18 per cent. Factors leading to death were peritonitis and pneumonia in three cases each, plastic peritonitis in three, ileus and pulmonary edema in two each, and cardiac dilatation and gastric fistula in one each. Average survival was 15 days.

III. PENICILLIN

PENICILLIN was administered in 34 cases in the period from 1945 to 1950. In addition, intraperitoneal sulfonamides were used in nine cases, average dose being 5 Grams. Ages ranged from 24 to 78 years, average being 46 years. Three of the patients were female, their ages being 25, 30 and 53 years. A previous ulcer history was given by 24 patients. There was no previous history in nine patients. In 17 cases the previous history was 5 years or less. Previous perforation had occurred in 2 patients. In one case the perforation occurred 9 years before, and the other patient had perforations 2½ and one year previously. Bleeding was noted in 3 cases. No perforations occurred during hospitalization. Abdominal x-rays were taken in 7 cases, pneumoperitoneum being found in 5. Site of perforation was gastric in 19, duodenal in 13, and pyloric in two. Duration of perforation in the survivors was 13 hours and in those terminating fatally 23 hours. Average age of survivors was 45 years and those terminating fatally 57 years. A correct diagnosis was made in 30 cases.

The surgical approach did not differ materially from the former groups. Nasogastric suction was used in 25 cases most commonly for 48 hours or longer. In several instances where pyloric obstruction or persistent ileus was a feature, suction was used for a longer period or was re-established shortly after having been discontinued.

Blood transfusions were given to 12 patients and parenteral fluids to all 34 patients.

Multiple intraperitoneal drains were used in one case. In 5 patients a single intraperitoneal drain was used. The subcutaneous tissue was drained in 17 patients, and closure without drainage was used in ten.

There were 21 non-fatal complications in 13 patients. Wound infection, wound dehiscence, persistent gastrointestinal bleeding and ileus were noted in each of three cases. In two instances atelectasis, subphrenic abscess and gastric dilatation developed. There was one instance each of pleural effusion, peritonitis and urinary retention.

With only three deaths, mortality rate was 9 per cent. The fatal complications were peritonitis in two; and subphrenic abscess, shock, intestinal obstruction and wound dehiscence in one each. The average hospitalization of the fatal cases was from 2 to 10 days with an average of 6 days.

IV. PENICILLIN PLUS STREPTOMYCIN

PENICILLIN and streptomycin were used in 42 cases from 1947 through 1952. Age range was 23 to 72 years with an average of 47. Seven patients were women, their ages being 69, 64, 60, 59, 54, 26 and 26. Previous history of ulcer was given by 28 patients, in 20 of whom the duration was less than 5 years. In 8 patients, there was no previous ulcer history. Previous perforations occurred in three

patients, 3, 4, and 12 years previously. Abdominal x-rays were made on 20 patients and revealed pneumoperitoneum in 14. In one of these, a pre-operative diagnosis of pancreatitis was ruled out because of the pneumoperitoneum. This patient had an equivocal serum amylase and physical findings when first seen. Site of perforation was gastric in 20, pyloric in seven and duodenal in 13. In two cases, site of perforation was not discovered. The average age of survivors was 46 years and in those who died, 67½ years. Duration of perforation in survivors was 12½ hours as opposed to 61 hours in those terminating fatally. Average hospitalization was 12 days. A correct diagnosis was made in 35 cases.

THE most common approach was a right paramedian incision. In a lesser number of cases, a midline or right pararectus incision was employed. In no case was a lower abdominal incision extended upwards, although in two instances, the operator was doubtful and made a short exploratory right transrectus incision at the level of the umbilicus. In both cases the incisions were extended upwards when the nature of the problem became evident. In two cases the perforation was found to be sealed off at the time of operation. These were of 12 and 48 hours' duration. One duodenal perforation was found sealed off by the fundus of the gall bladder. In one case, appendectomy was done prior to ulcer closure. The other diagnostic errors were appendicitis in two cases, pancreatitis in two, and ureteral colic in two. In one of the cases which terminated fatally, preliminary diagnosis was doubtful and the surgical procedure was abdominal drainage through a McBurney incision. This patient had symptoms of 120 hours' duration. Treatment of perforation was simple plication with inclusion of omentum, using interrupted heavy chromic sutures. In three cases, the omentum was sutured to the edge of the perforation because of fear of constricting the lumen or because the edges of the perforation were indurated and friable. Closure most commonly consisted of a continuous chromic suture in the posterior sheath, and interrupted chromic mattress sutures in the anterior sheath. Interrupted wire sutures were used in most of the midline incisions and in some of the rectus incisions. Retention sutures were used in several cases only.

In 32 cases, nasogastric suction was used, the average being for two days. Blood transfusions were given 28 patients and intravenous fluids to 40 patients.

Intraperitoneal drainage was used in seven cases. This consisted of a single rubber tissue drain through the operative wound only. The subcutaneous tissue only was drained in four patients. In 31 cases wounds were closed without drainage.

There were 27 non-fatal complications in 18 patients. These were ileus in four, persistent gastrointestinal bleeding in three, pneumonitis in three: atelectasis, bronchopneumonia, gastric dilatation, urinary retention, and electrolyte imbalance in each of two instances; and lobar pneumonia, wound infection, dehiscence, singultus, delirium tremens, sinus arrhythmia, and heart failure, once each.

There were two fatalities: a mortality rate of 5 per cent. The contributory causes were peritonitis in both, with pneumonia and pulmonary edema in one and pleural effusion in the other. Average survival was 11 days.

NON-OPERATIVE CASES

IN THREE cases, treatment was non-operative. Diagnosis was established on the basis of the clinical picture and the presence of pneumoperitoneum on x-ray. One, a severe cardiac, probably represents an evanescent perforation with spontaneous sealing. An abdominal x-ray shortly after admission appeared to demonstrate no pneumoperitoneum until reviewed the following day. By this time the patient was asymptomatic. This patient received no treatment. In the second case, surgery was felt to be contraindicated because of the poor physical status and age of 81 years. Treatment was by constant gastric suction and large doses of penicillin and streptomycin. Recovery was prompt and convalescence uneventful. In the third case initial response to conservative regime was prompt. Pneumoperitoneum was demonstrated by x-ray on the day after ad-

mission but by this time symptoms had abated.

Four patients were admitted *in extremis* and never were in good enough condition to justify laparotomy. Death occurred in an average of 2½ hours following admission. Average age was 71.

In nine cases, autopsy revealed previously unsuspected perforated peptic ulcer as the cause of death. Two deaths occurred on the surgical service, two on orthopedics and the remainder on the medical service.

MORTALITY AND MORBIDITY

DURATION of perforation, site of perforation and age have the greatest influence on morbidity and mortality. There is an increase with age, duration, and in gastric as contrasted with duodenal perforation. Average age of the patients for the entire operative group who succumbed was 54½ years as contrasted with an age of 46 in the survivors. Duration of perforation in those who recovered was 12 hours as compared to 29 hours in the fatal cases. Twenty of the 30 fatalities and 33 of the 47 complications followed gastric perforation.

The use of antibiotics has been attended by an increase in non-fatal complications, and also by an increase in the proportion of cases having uneventful postoperative convalescence. The effect of sulfonamides and antibiotics in decreasing mortality has been noted by Baritell,[3] Brown and Andrus,[6] Altemeier,[1] Jones *et al.*,[11] Turner,[25] Kingsbury and Peacock [13] and Mikal and Morrison.[17] The average decrease in mortality has been from about 30 per cent to between 6 and 7 per cent. McElhinney and Holzer [20] noted that *no subphrenic abscess had been encountered since penicillin had been used*. The increase in non-fatal complications probably represents the salvage for which antibiotics are responsible. There has been marked decrease in peritonitis, subphrenic abscess and empyema.

COMMENT

THE only notable clinical change was the increasing incidence among women. This has been noted in the series of Miller *et al.*[18]

The approach to the problem must be based on an understanding of the disease and its effect upon the bodily economy. The acute symptoms are initiated by sudden rupture of the base of a gastric or duodenal ulcer and escape of the highly irritating contents into the general peritoneal cavity. There is immediate and spreading chemical peritonitis which eventually involves most or all of the peritoneal surfaces. In an occasional case, the perforation is not free but is contained to some extent by previous adherence of omentum, parietes, or other viscera. The inflammatory response to the peritoneal irritation results in secretion of large amounts of fluids and electrolytes into the peritoneal cavity at the expense of the circulating body fluids. At first, this is essentially sterile but as time progresses, there is bacterial growth. Gastric hyperacidity is a protection against the entrance of pathogenic organisms. Conversely, perforations occurring in hypacidity or anacidity are likely to result in more organisms of greater pathogenicity. This probably explains the greater mortality in gastric as compared to duodenal perforation. The effects of gastrointestinal juices intraperitoneally were studied by Blalock.[5] The resulting metabolic alterations were found to be comparable to those in mechanical intestinal obstruction by Krieger *et al.*[14] The effect of chemical peritonitis and the resulting nutritional and biochemical imbalance in perforated ulcer were noted particularly by Graham.[7] Trauma, for instance, the manipulation incident to the fluoroscopic examination during a gastrointestinal x-ray series, may precipitate perforation. Perforation of peptic ulcers during or immediately following fluoroscopy has been noted infrequently. Cases have been reported by Winham and Pechstein,[27] Hayden and Schilling.[9] The incidence of radiographically evident pneumoperitoneum has been reported to vary from 60 to 90 per cent of cases by Johnson,[10] Williams and Hartzell,[26] Berson,[4] Thompson and Prout,[24] McElhinney and Holzer[20] and Mikal and Morrison.[17] Williams and Hartzell [26] indicated that a larger incidence of pneumoperitoneum was found if x-rays were taken in the left lateral decubitus position.

THE association of bleeding and perforation was found to be 20 per cent by Moore [21] in one series of cases. Ladin [15] reported closure of three perforated ulcers followed by massive hemorrhage. Similar cases have been reported by Shapiro and Schiff,[23] McCabe and Mersheimer,[19] Kahn and Kumpuris,[12] Saltzstein *et al.*[22] and Harrison and Cooper.[8] Associated bleeding and perforation was found to increase mortality and morbidity. Amendola [2] considered that the bleeding was often from an ulcer other than the one which had perforated and therefore the surgeon should be prepared for more than the usual simple closure. As age progresses, the inflammatory response to insult is less prompt and sustained. Sex plays no apparent part except that the female is less often suspected of perforation and most frequently suspected of disease originating in the pelvic organs. Failure to diagnose a perforated peptic ulcer is equivalent to a death sentence in a large proportion of cases. The incidence of missed diagnosis seems to be about 1 per cent, usually atypical or bizarre cases.

Lassen [16] observed that most commonly a second perforation was duodenal after a previous gastric perforation or at least more distal than the first gastric ulcer. This has been true in this series where reporting was sufficiently detailed to permit study.

If the escape of irritating gastric or duodenal fluid is contained by operative closure before bacterial growth, recovery can be expected with a minimum of complications. Likewise, gastric suction will remove most of the gastric secretion before escape into the peritoneal cavity and allow sealing of the defect. Should the escape of fluid continue, generalized peritonitis causes death by sepsis, dehydration and electrolyte imbalance. If chemical peritonitis persists without bacterial growth, a plastic peritonitis will result with multiple small intestinal obstructions. This explains the cases of long survival and gradual death by inanition.

From this series it would appear that *surgical intervention after 24 hours is contraindicated.* The perforation is usually sealed by this time and the peritoneum and omentum are better able to accomplish removal of the peritoneal contaminants than is transabdominal drainage.

It is apparent from the diversity of approach and treatment that the work of a considerable number of surgeons is expressed in this series. Many have died or retired from practice during these years. Some were frequent and active operators while a few were only occasional surgeons. This was more particularly true in the period up to 1945.

THE popularity of various approaches to the problems of adjuvant treatment is, of, course, reflected in a series of this type. Of particular interest was the increasing use of nasogastric suction, blood transfusions and parenteral fluids over the period of years. The increased use of these was not always advisable but it demonstrates an increasing awareness of their potential importance. Likewise, there was a steady diminution in the numbers and sites of postoperative drainage.

The treatment of the perforation was practically the same during the entire period of the study. The tendency for wound closure to depend upon interrupted sutures and on nonabsorbable sutures increased through the years. There has also been gradual abandonment of retention sutures.

It appears that the diminution in mortality is due primarily to the use of antibiotics, parenteral fluids and blood.

In this series there has been a marked increase in non-fatal complications in the period covered by this report. In part, this has been due to the control of infection by antibiotics and greater insight into the management of complications which formerly terminated fatally.

CONCLUSIONS

1. A series of 165 cases of perforated peptic ulcer in a community hospital over a 20-year period is presented.
2. There has been little change in the clinical picture except for the increased incidence among women.
3. The treatment of the perforation in this

institution has not changed radically.

4. Age, duration of perforation and site of perforation are the most important factors influencing morbidity and mortality. Increasing age, long duration and gastric as opposed to duodenal perforation have an adverse effect.

5. General use of parenteral fluids, transfusion and nasogastric suction in conjunction with sulfonamides and antibiotics plus the abandonment of intraperitoneal drainage have reduced mortality from 44 per cent to 5 per cent.

601 Grand Avenue

A bibliographic list of 27 citations and a display of six detailed tabulations will be found in Dr. Guthorn's reprints.

A New Digitalis Form

In the 180 years that have passed since Withering, digitalis remains as the only drug we have which is effective in congestive heart failure by acting at the source of the difficulty: the failing myocardium. Many different preparations of digitalis are available to the physician today.

Whole leaf digitalis may be given parenterally but is used almost exclusively by the oral route. Twenty per cent of it is absorbed from the gastrointestinal tract. Tincture of digitalis is little used today. It deteriorates with age. Accurate dosage is not always possible because it is usually dispensed in drops. A similar whole leaf preparation exists from the lanata plant and is known as digilanid. It is little used. Digitoxin is more widely used than any of the other preparations of digitalis. It was originally popular because the medical profession was told that 1.2 milligrams of this drug sufficed to digitalize any cardiac patient. Actually, the digitalizing dose of this preparation varies from 1.2 to 2 milligrams, and excretion will vary from individual to individual. No more than 44 per cent of the drug is excreted within two weeks after it is discontinued. It may take five to six weeks to rid the patient completely of digitoxin.

There is also available a glycosidal constituent, trade-named as Gitalin.® This is completely absorbed from the gastrointestinal tract, and following discontinuance it is almost completely excreted within 7 days. The digitalizing dose is one-third of the toxic dose. With all other prepartions which are available to us, digitalizing dose is two-thirds of the toxic dose. Thus, it has a wider margin of safety. Ehrlich* says it is the digitalis of choice except in advanced myocardial disease with much fibrosis where excessive irritability is feared. In this case, the use of digoxin is recommended.

*Ehrlich, J. C.: Arizona Medicine, 12:239 (June 1955).

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Digitalis Toxicity*

Digitalis is no casual drug, to be dispensed lightly. It is a drug with a kick. The extent of that kick is illustrated in this well worked-out case report.

Occasionally one is abruptly reawakened to the dangers of a drug by a startling case. When a patient was admitted to the Martland Medical Center for the eighth time because of a cardiac arrhythmia and extreme digitalis sensitivity, a review of his voluminous records revealed an unusual story. The story lighted up many of the manifestations of digitalis toxicity and errors on the part of patient and physician which can result in toxic reactions to digitalis. We present this case and a review of the physiology and pharmacology of digitalis, as a reminder of the precautions which must be observed in prescribing digitalis.

A 67-year old male was first treated for arteriosclerotic heart disease in February 1951. Because of syncope, dizziness, orthopnea and cough, he was digitalized at that time. Digitalis, 1½ grains powdered leaf was taken daily, under the direction of his family physician.

In July 1952 he was seen at the Martland Medical Center for the first time because of paroxysmal tachycardia. Digitalis was stopped and the symptoms subsided. In September 1952 he was again seen at the Martland Medical Center because of recurrence of dizziness and syncope. He was told to take 1½ grains of powdered leaf digitalis three times that day. Through misunderstanding, he continued on this for two weeks. He then developed severe nausea and dizziness and he returned to the Martland Medical Center where digitalis was discontinued and the symptoms subsided. He apparently received no digitalis for the next six months.

In April 1953 the patient was again given digitalis by his private physician because of paroxysmal tachycardia. Soon after the initial dose he developed syncope and was readmitted to the Martland Medical Center. Electrocardiograms showed sinus bradycardia with first degree heart block. The P-R interval was 0.24 seconds. Heart rate was 47 per minute. It was felt that the patient had digitalis toxicity and the drug was discontinued. Symptoms subsided and the patient was discharged.

On July 2, 1953, he was admitted to the Martland Medical Center for the fifth time because of fainting spells and tachycardia. He was given 0.8 milligrams of a proprietary lanatoside[1] intramuscularly and maintained on a digitalis glycoside[2] 0.25 milligrams daily. The symptoms subsided and he was discharged after one week. Two days later he complained of the same symptoms. He returned to his physician and was again digitalized, this time with digitoxin, 1.2 milligrams intramuscularly over a 24 hour period. Dizziness and syncope became worse and on July 19, 1953 he was readmitted to the hospital. On admission he had a tachycardia. He failed to mention the previous treatment with digitalis and was given the same proprietary lanatoside,[1] 0.8 milligrams intramuscularly. He soon developed severe nausea and vomiting and described visual halos. Electrocardiogram at this time showed auricular flutter with varying heart block. The patient was treated with procaine amide[3] and with potassium chloride. Electrocardiogram showed reversion to regular sinus rhythm with auricular and nodal premature contractions. The P-R interval was 0.22 seconds. The patient was discharged and warned to take no digitalis. In November 1953 he was readmitted to the Martland Medical Center with auricular flutter and 2:1 A-V block. He denied taking digitalis. Treatment with bed rest and procaine amide[3] was successful in reverting the rhythm to regular sinus rhythm.

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On December 5, 1953 the patient was admitted to the Martland Medical Center for the eighth time because of palpitations, precordial pain and dizziness of five days' duration. He denied taking digitalis or any other medication. There never had been a history of heavy alcoholic intake. He was a moderate coffee drinker and there was no apparent relationship between his symptoms and any particular activity.

On admission, we saw a well developed, well nourished male in no acute distress. Head and neck were normal. Examination of the eyes, ears, nose and throat revealed no abnormality. The chest was symmetrical with equal expansions. The lungs were clear to percussion and auscultation. Blood pressure was 138/74. The heart had a totally irregular rhythm with an apical rate of 88 per minute. A grade III systolic murmur was present at the apex. At the base over the aortic area, the second heart sound was replaced by a soft blowing diastolic murmur. The abdomen was soft. No tenderness, masses or viscera were palpable. The remainder of the physical examination revealed normal findings.

Laboratory studies revealed a hemoglobin of 12.7 Grams. Wassermann was negative. The red blood cell count was 4,300,000. The white blood cell count was 4,900 with 82 per cent polymorphonuclears and 18 per cent lymphocytes. The urine had a specific gravity of 1.021 and a trace of albumin. There was no glycosuria and the microscopic examination revealed no abnormality. Blood urea nitrogen was 16 milligrams per cent.

The admission electrocardiogram showed auricular flutter with varying heart block. The patient was given procaine amide,[3] 5 Grams intramuscularly, repeated in 12 hours with no change in the cardiac rhythm. Two days later, he still showed auricular flutter at a rate of 320 per minute, with 2:1 block. He was then given quinidine, 6 grains every 4 hours. After seven days the only change noted was slowing of the flutter rate to 190 per minute. Quinidine was discontinued after two weeks with no change in the rthythm. Five days later, however, electrocardiogram showed auricular fibrillation with a ventricular rate of 120 per minute. On December 30, 1953, after receiving no medication for a week, we gave him digitoxin, 1.2 milligrams orally in divided doses over a 72 hour period to slow the ventricular rate. On the third day he developed yellow vision, nausea and vomiting and the digitoxin was stopped. Electrocardiogram on January 2, 1954 revealed auricular fibrillation with frequent premature ventricular contractions. He was then given procaine amide,[3] 1 Gram daily in 4 divided doses and potassium chloride, 1 Gram three times daily. Four days later electrocardiogram showed reversion to regular sinus rhythm with P-R interval 0.23 seconds. All medication was stopped and the patient remained asymptomatic for one week.

On January 15, 1954 he had a recurrence of auricular fibrillation and was given 250 milligrams of procaine amide[3] every four hours for three days, without effect. On January 20, 1954, under close observation, a single 0.2 milligram dose of digitoxin was given orally. Auricular fibrillation persisted with reappearance of premature ventricular contractions. The patient was again given a Gram of procaine amide[3] daily for one week. He then showed auricular flutter with varying heart block and auricular and ventricular premature contractions. All medication was discontinued and the premature contractions disappeared although the flutter persisted. On February 3, 1954 quinidine sulfate was started, 6 grains every 3 hours. After two days the flutter rate slowed from 240 to 134 per minute with 2:1 block. On February 6, the rhythm became regular and all medication was discontinued. Electrocardiogram on February 8, 1954 revealed sinus bradycardia with first degree heart block. The P-R interval was 0.20 seconds and the patient was asymptomatic. On February 10, another test was performed with digitalis. The patient was given 0.45 milligrams of a digitalis glycoside[2] in three divided doses, each four hours apart, masked in orange juice. Eight hours after the last dose, the patient became nauseated and began to vomit. Electrocardiogram revealed sinus bradycardia and first degree heart block, with a heart rate of 37 per minute and P-R interval of 0.22 seconds. All medication was withheld and after three days the nausea subsided, appetite returned and the patient felt well. The patient continued asymptomatic and one month later electrocardiogram revealed a sinus bradycardia with a heart rate of 50 per minute and a normal P-R interval of 0.18 seconds.

DIGITALIS toxicity is not an idiosyncrasy or allergy but an exaggeration of the known actions of the drug. The toxic effects on the heart, therefore, can be predicted by imagining the results of magnifying the various physiological actions.

On the failing heart digitalis normally exerts the following actions:[4]

1. Contractility is increased.
2. Rhythmicity is depressed in the S-A node and enhanced in the A-V node.
3. Conductivity is delayed by two actions, vagal stimulation and direct depression of the conduction mechanism.
4. Irritability is increased.

Although the overall effect of the various actions of digitalis is to improve the failing heart, such is not the case with the normal heart. In the normal heart digitalis decreases the cardiac output, diminishes the volume of venous return and increases peripheral arteriolar resistance.[5]

The signs of digitalis overdose are varied and almost any type of change can occur in the electrocardiogram. The following aberrations [6] are known to occur as a result of digitalis toxicity [7] to the heart: sinus arrest, sino-auricular block, auricular premature contractions, paroxysmal or sustained auricular flutter or fibrillation, all degrees of auriculo-ventricular block, nodal tachycardia, auriculo-ventricular dissociation with idioventricular rhythm, ventricular premature contractions, bigeminal rhythm, ventricular tachycardia, ventricular fibrillation. S-T and T wave changes in the electrocardiogram, although signs of digitalis effect in therapeutic doses, may be the only changes in some cases of digitalis poisoning.[8]

DIGITALIS toxicity involves other systems as well as the cardiovascular apparatus. Toxic action on the gastrointestinal system produces nausea and vomiting. This is the result of two actions; direct gastric irritation and central stimulation of the medullary vomiting center. Anorexia is a common toxic sign. Diarrhea also may occur. Visual and central nervous system effects may produce visual halos and colored vision, usually yellow but occasionally green, blue or red. Transient amblyopia, headache, scotomata, psychic changes and retrobulbar neuritis [10] have been reported.[4,9]

Toxic effects of digitalis on the cardiovascular system are separate from toxic effects on the gastrointestinal system, and if the gastrointestinal tract is by-passed by parenteral administration, the initial vomiting due to the local gastric irritation of digitalis can be eliminated and greater cardiac action produced before vomiting occurs due to medullary stimulation.[11]

Therapeutic indications for digitalis include congestive heart failure, whatever the type or accompanying arrhythmias may be; signs of diminished cardiac reserve (pulmonary edema, paroxysmal nocturnal dyspnea, gallop rhythm) and the auricular arrhythmias.

Digitalis is contraindicated in the following situations: when there is evidence of digitalis toxicity; in ventricular tachycardia, unless in heart failure; in carotid sinus sensitivity where vagal stimulation may induce attacks; in complete heart block, unless in heart failure; in any situation without the proper indications for digitalis.

COMMENT

THIS case of repeated digitalis poisoning is a striking example of the dangerous potentialities of the drug. The patient showed an unusual sensitivity, even to small doses. Whether the tremendous overdoses of digitalis earlier in his illness contributed to this sensitivity is an interesting question. It can be said with certainty that had the drug been given only when properly indicated, many episodes of toxicity would have been prevented. Digitalis must never be used on a new patient without full knowledge of previous digitalis therapy. There is no substitute for a careful history.

This patient demonstrated many of the electrocardiographic manifestations of digitalis toxicity during his troubled experiences with the drug, although it is apparent that he had auricular arrhythmias on occasions without digitalis. In July 1953, following the unusual experience of three full digitalizations within a two week period, electrocardiograms showed auricular flutter with varying A-V block. At other times following digitalis, it showed sinus bradycardia, first degree heart block, auricular flutter with 2:1 A-V block, auricular fibrillation with ventricular premature contractions and regular sinus rhythm with auricular and nodal premature contractions.

Nausea and vomiting were seen many times in this patient as signs of digitalis toxicity to the gastrointestinal tract. Visual halos and yellow vision indicated that he also had central nervous system effects of digitalis overdose.

The patient demonstrated several other interesting features of digitalis effect in the course of his many reactions to the drug. In February 1954, following recovery from digitalis toxicity, a test with 0.45 milligrams of digitoxin in three divided oral doses resulted in violent nausea and vomiting with only slight changes in the electrocardiogram. There was

increase in bradycardia and prolongation of the P-R interval from 0.20 to 0.22 seconds. In view of the marked cardiac reactions to larger doses at other times, this predominantly gastrointestinal reaction to a small dose of digitalis may illustrate the separate nature of gastrointestinal and cardiac effects of digitalis toxicity. In observing the effects of different glycosides on this patient, he served as a human bio-assay indicator of digitalis effect. When digitoxin was given electrocardiographic signs of toxicity persisted for 21 days. With Digoxin® however, the signs of toxicity, which appeared on the electrocardiogram within 24 hours of the first dose (prolonged P-R interval), had disappeared at the time of the next cardiogram one week later. This suggests why digitoxin is not considered as safe a glycoside.[9]

The treatment of digitalis toxicity requires withdrawal of the drug and the use of other agents to correct the abnormalities produced.[4] Frequently cessation of digitalis therapy will suffice. If necessary, atropine may be used to abolish the vagal effects. Quinidine may be effective against some arrhythmias, although some feel that its use is dangerous[13] in the digitalized patient. Potassium salts, magnesium sulfate and procaine amide[3] are used and in this case were helpful.

Far more important than treatment of digitalis toxicity is the appreciation of the inherent dangers of digitalis. Careful consideration of the differences in margins of safety of the various digitalis preparations available and judicious appraisal of each situation in which digitalis therapy is contemplated will result in more satisfactory results and less need to treat digitalis poisoning.

SUMMARY

1. A case of repeated digitalis poisoning is presented demonstrating many of the toxic manifestations, errors on the part of patient and physician responsible for toxicity and treatment of different manifestations of digitalis toxicity.

2. The pharmacology of digitalis is presented with special reference to physiology, toxicity, indications and contraindications.

3. The case demonstrates the dangerous potentialities of digitalis and the need for judicious appraisal of each situation in which digitalis is contemplated, with full knowledge of previous digitalis therapy.

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Home Treatment of Tuberculosis*

While the spirit of the times is towards more and more hospitalization of acute illnesses, the reverse trend is noted for chronic diseases. The home care of the tuberculosis patient, though not a procedure for the timid doctor or for the stupid patient, is perfectly feasible under certain conditions. Dr. Potter here spells out those conditions.

While home care of tuberculosis has been practiced in the past, it was not always the program of choice. Most often it was forced on the practitioner by obstinate patients who would not hear of institutionalization or by those who, after a short sojourn in a sanatorium, refused to remain long enough to complete treatment. In the late thirties there was a short lived attempt to utilize pneumothorax in selected individuals without hospitalization.

In the past several years, however, home treatment as a procedure of choice in selected cases has become a common practice. It has aroused formidable controversy. Differences of opinion are, in some instances, due to difficulty in parting with the past; in others to the assumption that home care is a substitute for rest; and in still others, to legitimate concern for the public health effects of such a program.

Home treatment as herein used, is the initial application of institutional regimens on a home basis for patients whose disease is amenable to either home or institutional treatment but who select the former; for those in this group who either by choice, persuasion or for whatever other reasons, choose hospitalization but after a short stay release themselves; for individuals, regardless of character or extent of disease, who are prematurely discharged but whose sputum is converted and the tuberculosis stabilized or with high potentialities for becoming so; and finally for persons who are cooperative but psychologically unsuited to hospital routine. Among the latter are many who repeatedly release themselves from hospitals after a short residence. In this group are also persons in the fifth, sixth or seventh decades of life, known to have great difficulty or no capacity to adjust to sanatorium care. In all of these, the peace of mind that accompanies home treatment outweighs all that institutionalization offers.

EXCLUSIONS

Not included in this program are patients who are discharged from sanatoria with positive sputum after having reached maximum benefits. Some congenial arrangement should be made by each community for segregating these unless home conditions are so fortuitous that no children or adolescents are

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present and the nursing service is such as to assure constant adherence to precautionary measures by these individuals. Also excluded are unselected cases being treated while awaiting admission. This practice has contributed much to the welfare of the individual victim and to the prevention of spread of tuberculosis in communities in which the bed shortage offers no alternative program. It is, nevertheless, a makeshift arrangement which should be abandoned as soon as local circumstances can be altered.

OUTLINE OF STUDY

THE group under consideration comprises 123 white patients treated since January 1, 1949 and evaluated as of March 1, 1956. Their characteristics are shown in Table 1.

TABLE 1.

	Cases	Median Age	Youngest	Oldest
Male	48	35	15	69
Female	75	35	15	69
	123			

TABLE 2.

One previous hospitalization	54	or	44%
More than one previous hospitalization	14	or	11%
No previous hospitalization	55	or	45%
	123	or	100%
Known contacts	22	or	18%
Positive sputum	54	or	44%
Negative sputum	69	or	56%

Females predominated. There was no difference in the minimum and maximum ages between the sexes with a mean age of 35 years.

It is interesting to note (Table 2) that 68 patients or 55 per cent had been previously hospitalized, 14 of these more than once. Only 22 cases or 18 per cent gave a history of known contact with tuberculosis. The number of patients whose sputum or gastric contents failed to reveal tubercle bacilli surpassed the positive group.

I CALL your attention to Table 3. Cases are divided almost equally between those that had not had reinfection tuberculosis before and those whose previously existing disease had either become reactivated or a new process superimposed. Most of the latter had been under my observation for years and the recurrent disease was discovered as a chance finding during routine re-visits and with absence of symptoms as frequently as in the ones who had no pre-existing tuberculosis.

Table 4 may be somewhat misleading in that it indicates that 20 per cent of the patients had already had far advanced tuberculosis on the initial examination. The designation of "far advanced" usually brings to one's mind an unfavorable picture as to extent and character of the disease, chain of symptoms and prognosis.

TABLE 3.

Character of Disease		Number	Duration of Disease
New Disease 61 cases	Survey cases No symptoms	18	None
	With symptoms	43	1 to 24 months Average 4.5 months
Recurrent Disease 62 cases			Relapse interval 1-30 years Average 7 years

TABLE 4.

Extent of Disease	Number of Cases
Minimal	31
Mod. advanced	56
Far advanced	25
Idiopathic effusion	5
Tracheo bronchitis	4
Laryngitis	1
Lymph adenitis	1

Yet these circumstances did not exist in the 25 cases under discussion. Only two patients showed moderate fever which subsided after a few days of treatment. In no case were troublesome symptoms present. The classification of "far advanced" was assigned to these patients because of distribution of the tuberculosis, the size of the cavity or cavities and the extent of the previously existing lesions in accordance with the suggestions of the National Tuberculosis Association.

Of the total number of patients contributing to this study, 47 or 38 per cent revealed cavitation (Tables 5 and 6). In only three cases was the target point consisting of obliteration of cavity, negative sputum and stability of the disease not achieved.

TABLE 5. STATUS OF COMPLETED CASES

	Minimum (months)	Maximum (months)	Mean (months)
Duration of treatment	3	24	12
Post-treatment observation	6	72	28
Interval of closure	4	12	7

Total cases	78
Cavity cases	30
With closed cavities	30
Supplementary pneumothorax	8
Supplementary excision	4

TABLE 6. STATUS OF INCOMPLETED CASES, MARCH 1956

Total number of cases		45
Cavity cases		17
Cavities closed		11
(one with supplementary pneumothorax)		
(one with supplementary excision)		
Cavities open		6
(three open negative)		
(three open positive)		
Clinical condition:		
Improved	42	
Unimproved	2	
Died	1	

A point to be stressed was the use of supplementary pneumothorax and excisional surgery in the 41 patients whose cavities closed. The "open negative cavity" which was demonstrated in three cases is a fascinating observation since the introduction of chemotherapy, particularly since the use of isoniazids, and about which our thoughts as to management have not crystallized. In any event, the three patients present contraindications to surgery and therefore are being continued under medical supervision.

CHEMOTHERAPY

CONCERNING the various antibiotics, Table 7 is self explanatory. Note that 22 patients had had previous drug therapy. All belonged to the group of "recurrent disease" (see Table 3). The minimal treatment of three months was confined to a handful of patients who developed toxicity. While streptomycin in combination with either para-aminosalicylic acid or isoniazid, or both was utilized in 64 cases, the combination of INH and PAS was given in 85 per cent of those treated in the past two years. The three drugs (streptomycin, INH and PAS) were given simultaneously in only 14 patients when special indications were present.

TABLE 7. CHEMOTHERAPEUTIC AGENTS

I. PREVIOUS THERAPY

19: Streptomycin + Para-aminosalicylic acid
2: Pyrazinamide®
1: Tibione®

II. CHEMOTHERAPY AT HOME

25: Streptomycin + Para-aminosalicylic acid
5: Streptomycin + Isoniazid
34: Streptomycin, isoniazid and para-aminosalicylic acid in varying combinations
59: Isoniazid + Para-aminosalicylic acid

The tuberculosis recurred in two patients after a course of chemotherapy. In one who had had only six months of therapy, recurrence took place two years later. Drug therapy

was re-introduced resulting in complete recovery. In the second patient (who had been receiving bilateral pneumothorax for three years) the residual infiltrations became accentuated under collapse. He received chemotherapy for 18 months. On abandonment of the pneumothorax two years after completion of drug treatment, the original cavity in the apex of the left lower lobe reopened and pericavernous confluent bronchopneumonia with fever appeared. He is responding favorably once again to antibiotics in preparation for excisional surgery.

COMMENT

HOME care is not wise unless one eliminates those who are not likely to cooperate, whose economic and family surroundings are not compatible or whose intelligence and sense of responsibility are not such as to assure proper prevention against infecting others. Home care is also unwise if the community does not provide adequate public health nursing service. However, I cannot agree with those who assert that everyone with a tuberculous lesion, no matter how insignificant, must "put in time" in an institution if for no other reason than to obtain an "education." By this is usually meant the development of an attitude of living in symbiosis with one's disease under constant self-threat of the possible consequences if the "rules" are not followed. Having been an institutional man myself for over 25 years, I am convinced that hospitalization also has its negative educational phase which, in my experience, leaves lasting impressions with those most likely to follow sound medical advice regardless of hospitalization. Just to mention a few effects of this negative educational phase, I refer you to the insecurity of the future which is generated by viewing for months those who succumb, the "repeaters" and the hopelessly ill, break in the family integrity, financial loss or embarrassment by work stoppage, the development of dependency on others and relinquishing, even though temporarily, the happiness of one's home.

There are those who write the program off with the statement "I do not believe that cures will be as lasting as with sanatorium care." This fails to take into consideration the fact that prior to the introduction of antimicrobial therapy, the accumulative progression or relapse rate with sanatorium treatment ranged between 22 and 55 per cent. While comparable observation intervals with the use of antituberculous drugs are not yet available, everyone is impressed with the strikingly lower rates thus far, especially since prolonged therapy. Moreover, my observations indicate that this trend is no different when treatment is given at home.

Home treatment as herein defined indicates rest but not in the form of complete bed rest in every instance. The degree of rest was dictated by the extent and character of the existing tuberculosis and its constitutional effect and ranged from no rest in the asymptomatic cases to complete rest in the very sick.

Strict bed rest has been overstressed. Statistically, long range results are no better than when rest is modified. As in other unrelated medical conditions a concept of rest has been evolved more in conformity with our knowledge of pathologic physiology. With the development of prolonged multiple drug therapy even more leeway appears justified. Mitchell [1] expresses the current view when he states "We can hardly avoid accepting the judgment of many thousands of physicians, past and present, that rest does *something* to help the body heal tuberculosis. Acceptance of this part, however, does not mean that we know how much and what kind of rest therapy to use. In short, rest is effective treatment, but is it needed in all cases as an adjunct to prolonged multiple chemotherapy, and when needed, how much?"

In this connection, note the clinical experiment with early ambulation of patients at the

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National Jewish Hospital in Denver.[2] Apparently the immediate results are very favorable.

COMMUNITY HAZARDS

WHAT of the objections raised to home care because of the potential hazards to the community? This objection is certainly not valid for the negative sputum cases. As for the bacillary patients, individuals who do not possess the intelligence to appreciate the contagiousness of the disease (or whose home conditions do not lend themselves to accepted precautionary measures) should not be selected for home treatment. The community is safeguarded by withholding privileges for social contact outside the home until conversion takes place; usually within several weeks. This holds true in cavitary cases. The sputum becomes negative weeks to months before final obliteration of cavity. Conversion can and should be expedited by the early use of collapse measures or excisional surgery in addition to chemotherapy. I do not believe in awaiting a set time for rendering an individual abacillary before intervening with supplementary surgical measures. In appropriate cases, such means may be used simultaneously with antibiotics or within several weeks when it becomes evident that the chances are heavily against spontaneous conversion or obliteration of cavities.

CRITERIA FOR SELECTION

OTHER conditions being favorable, the following may be considered for non-institutional care:

(1) Minimal tuberculosis without symptoms, negative sputum and the determination of activity has to await serial roentgenograms.

(2) Minimal tuberculosis, negative sputum and mild activity. In this group and group one patients, I have permitted continuance of work, provided it was not strenuous, for those gainfully employed and essential light house duties for married women. Rest would be provided by forbidding all extra work activities in the former and rest periods throughout the day for the housewife.

(3) More extensive active disease, regardless of sputum. Rest is insisted upon, the degree depending on the type of tuberculosis and the tempo of activity. The duration of inactivity, partial or complete, was determined by the response of the individual to treatment.

The physician's experience and judgment may be taxed from time to time in deciding for or against hospitalization in the more extensive disease group 3 mentioned above. More important, however, is to know which patients should be unequivocally advised against home care regardless of favorable economic and home conditions. The following, in my opinion, should be hospitalized:

(A) Persons presenting extensive soft bilateral tuberculosis or tuberculous pneumonia, large or multiple cavities, marked symptoms and other constitutional effects requiring not only rest but also nursing care and frequent medical attention.

(B) Miliary tuberculosis with or without meningitis.

(C) Tuberculous meningitis.

(D) Selected cases of pleural effusion with or without parenchymal lesions.

(E) Extra-pulmonary tuberculosis, especially of the bones and joints, requiring frequent observation to choose the appropriate time for surgical intervention.

(F) Patients who fail to show satisfactory response to home treatment.

HOME MANAGEMENT

REASSURING the individual and outlining a program is only part of the physician's responsibility. Practical knowledge and judgment are essential in the selection of drugs and dosage and supplementary measures at the optimum time. Occasions arise when one must become cognizant of the need for a change in the current outline of treatment—an awareness which comes only with experience. You cannot expect the internist or the general practitioner not trained in tuberculosis to supply the maximum professional needs to the patient

without fortifying himself with the advice of one who has had such training. A physician should not undertake the task without the supervision of a competent chest internist.

CONCLUSIONS

IN THE words of Jones,[3] "It is no longer practical to discuss whether or not home care is a good idea since it is already in practice in many areas. What is needed now is a critical evaluation of unhospitalized patients. Criteria are needed for selection of patients and for providing medical care suitable to individual circumstances."

SUMMARY

1. One hundred twenty-three home patients have been treated since January 1, 1949 and evaluated as of March 1, 1956.

2. In 31 cases, the disease was minimal; 56 moderately advanced, 25 far advanced and eleven had various forms of extra-pulmonary tuberculosis.

3. Forty-seven patients had cavitation. Obliteration was achieved in 41 of these.

4. Sixty-eight patients or 55 per cent had had previous hospitalization; 14 more than once.

5. Fifty-four cases of the entire series showed tubercle bacilli on the initial examination or shortly thereafter.

6. Conversion of sputum in those who responded to treatment occurred within several weeks and preceded closure of cavity by weeks or months.

7. Average period of chemotherapy was 12 months.

8. Target point was not reached in three patients. There was recurrence with subsequent stabilization in two others.

9. Indications and contraindications for home care are enumerated.

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Anorexia, Colored Socks and Vitamins

Doctors who answer questions for other doctors tangle with such knotty problems as: Should football players be given extra vitamins; are colored socks bad for sore feet, and what can be done with a four-year-old child who refuses food?

The consultants came up with the following answers in the October 15 Journal of the American Medical Association:

All "mass medicine," including vitamins and iron in daily doses, is bad medicine for athletes. The consultant quoted a resolution by a joint committee from the National Education Association and the A.M.A.

It disapproved medicine or oxygen administration because players begin to expect it, and are encouraged to exert themselves beyond the limits they have learned "from instinct and experience." Giving drugs to stimulate athletes to greater activity or lessen the pain of an injury so they can keep playing is "poor medicine and worse education."

About colored socks: a consultant said wearing them while suffering open foot sores "involves no common peril." Wearing white socks —a common recommendation for infections or other sores—is probably not necessary. Sometimes colored socks cause trouble, but only because of an allergy to dye or yarn.

The four-year-old who won't eat unless her parents feed her just needs to make "a new start in life," another consultant said. He recommended giving "a complete change" at mealtime—a new place to eat, different dishes, and even different people to serve her. Giving her favorite foods and a dull-edged knife to practice cutting and spreading will help. So will eating with other children.

A short stay in the hospital—without parents—is a good last resort. Furthermore, there's no real reason to worry, he said. The child probably won't go without food for more than three days anyway.

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Gastro-Intestinal Bleeding During Treatment for Hypertension

Hydralazine and reserpine may drop the blood pressure. But they can also promote bleeding from the upper gastro-intestinal tract. A ganglionic blocking agent such as hexamethonium is recommended for the treatment of high blood pressure in a patient who has a gastric or duodenal ulcer.

The drugs now used in the medical management of hypertension are potent agencies. They can and do produce side-effects. This is well documented in the literature. Bleeding from the upper gastro-intestinal tract during drug treatment of hypertension has been reported.[1,2,3] Since hypertension and upper gastro-intestinal lesions are so common, they frequently co-exist. It is therefore of value to report three more cases of bleeding during the medical treatment of hypertension.

CASE ONE

A 45-year old man sought advice because of hypertension which had existed for at least eight years. There were no cardiac, renal nor cerebral complaints. He had a two-year history of periodically recurring post prandial epigastric pain but no episode of bleeding. His mother had died of a stroke in her early fifties. He had a grade-3 hypertensive retinopathy but the cardiac measurements and the electrocardiogram were within normal limits. There was no albuminuria.

Rauwolfia serpentina, 2 milligrams, three times a day, was prescribed. A few months later, because of a recurrence of ulcer pain, propantheline* and Gelusil® were given. The relief of pain was prompt. Five months later hydralazine* was added to the treatment and the blood pressure was maintained at a fairly satisfactory level on a dosage of 200 milligrams of hydralazine and 6 milligrams of rauwolfia daily. But after 3 months of this, he complained of weakness and the passage of many tarry stools which had a 4 plus guaiac reaction. Red cell count was 2,590,000. Hemoglobin was 7 Grams. The drugs were discontinued. The patient made a quick recovery after treatment with blood transfusions, rest and diet.

X-ray revealed a duodenal ulcer. He has since been well maintained on a combination of pentolinium tartrate (Ansolysen®) and phenobarbital without further evidence of bleeding nor recurrence of pain. Anticholinergic drugs have not been needed.

CASE TWO

A 48-year old woman had a ten-year history of hypertension. She had had a known duodenal ulcer with recurrent activity for eight years. There were two episodes of bleeding, eight and two years previously. She was subject to frequent headaches and a nocturia but had no cardiac complaints. Her mother died of a "stroke" in her sixties. She was an obese woman with a grade-2 hypertensive retinopathy, a moderately enlarged left ventricle and the electrocardiographic pattern of "left ventricular strain."

Hexamethonium chloride was given in gradually increasing doses up to 2 Grams daily. This dosage

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*We used the Searle brand of propantheline tradenamed Probanthine® and the Ciba brand of hydralazine tradenamed Apresoline®.

did not effect a satisfactory drop in blood pressure and hydralazine (Apresoline®) in dosage of 200 milligrams daily was added to the treatment. A year later, because of tarry stools, pallor and a hemoglobin of 8 Grams, she was hospitalized and treated with blood transfusions, rest and diet.

She was again placed on hexamethonium but five months later, a recurrence of severe bleeding necessitated a subtotal gastrectomy.

CASE THREE

A 58-year old man was admitted to the hospital because of acute onset of coma and left hemiplegia. The coma and hemiplegia disappeared in three hours. Blood pressure was 260/130 on admission. Hydralazine (Apresoline®) 50 milligrams and reserpine 0.25 milligrams (each t.i.d.) were given for three weeks. Then the drugs were discontinued because of nausea, abdominal cramps and diarrhea. Stools showed a postive guaiac reaction. Red cell count was 2,460,000. Hemoglobin was 7 Grams. Treatment consisted of transfusions, rest and diet. This patient had a roentgenologically verified hiatus hernia but no definite ulcer.

Hydralazine (Apresoline®) has an *in vitro* antihistaminase action. The drug provokes many side effects [4] such as urticaria, lacrimation, nasal congestion, headaches, and periorbital edema. In general, these side-effects suggest [5] a histamine action. Histamine acts directly on the parietal cells of the stomach resulting in increased hydrochloric acid. Since this action is direct rather than mediated through the autonomic nervous system, anticholinergic drugs are ineffectual neutralizing agents and offer no protection to an ulcer against this stimulating action.

Reserpine stimulates both secretory and motor activities in the gastro-intestinal tract.[6] There is an increase in both the volume of gastric juice and in its hydrochloric acid content. This action was clearly demonstrated by Plummer *et al.*[6] They noted miosis and bradycardia following the administration of reserpine, indicating a preponderant para-sympathetic action due either to an absolute increase in para-sympathetic action or to a decrease in sympathetic activity. The stimulating effects of reserpine on the gastro-intestinal tract were reduced by an anticholinergic drug.

Hexamethonium inhibits the secretion of hydrochloric acid by the stomach both in the resting state and after insulin. It also depresses the motility of the stomach.[7] Such effects favor the healing of an ulcer and there is clinical confirmation in the frequent relief of ulcer pain during treatment with hexamethonium. Bleeding in peptic ulcers has been reported following surgical sympathectomies [2] and it has been postulated that this is due to unopposed parasympathetic activity. It has been inferred that the same effect on the stomach may be caused by ganglionic blockading agents. This inference is not justifiable since drug ganglionic blockade very definitely affects parasympathetic as well as sympathetic activities. Furthermore, Smithwick and Kneisel [8] did not find any increase in hydrochloric acid formation following sympathectomy.

SUMMARY AND CONCLUSIONS

1. Three cases of upper gastro-intestinal bleeding during medical treatment of hypertension are reported.

2. Hydralazine and reserpine should be used cautiously if at all in the presence of an upper gastro-intestinal lesion. If reserpine is used, it should be combined with an anticholinergic drug. Anticholinergic drugs should not neutralize the effect of hydralazine since there is probably a direct histamine action on the parietal cells of the stomach.

3. A ganglionic blockading agent such as hexamethonium, because of its depressive effect on gastric secretion and motility, probably exerts a beneficial influence on an ulcer and is therefore the drug of choice in the treatment of hypertension in the presence of an upper gastro-intestinal tract lesion.

83 Bentley Avenue

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Jacob Bleiberg, M.D.

Newark

Treatment of Subacute and Chronic Dermatoses†

With a Tar Extract-Hydrocortisone Cream

A coal tar-hydrocortisone cream was found amazingly effective in the treatment of a variety of acute and chronic skin disease. Even a case of psoriasis seems to have been helped.

The value of topical applications of hydrocortisone preparations in the treatment of various inflammatory dermatoses has been demonstrated [1] during recent years. The mechanism of the steroid is obscure, but recent experimental studies furnish some clues.

Menkin [2] suggested that hydrocortisone acts at the cellular level, inhibiting the production of chemical factors involved in inflammatory reactions; *e.g.,* leukotoxine and a leukocytosis-stimulating factor. Baker and his associates,[3] have shown that local application of corticosteroids decreases both the amount and the reactivity of the connective tissue substrate in the treated area. One cannot, of course, exclude the likelihood that the phenomena observed by the two groups of investigators are interrelated.

Attempts to demonstrate absorption of hydrocortisone, using the method of determining influence on circulating eosinophile counts,[4] or urinary excretion of steroids,[5] appeared to indicate that absorption does not occur. Recently, however, Malkinson and Ferguson [6] demonstrated in human subjects that inunction with a carbon [14]-labeled hydrocortisone ointment was followed by urinary excretion of radioactive hydrocortisone derivatives. Radioactivity was not detected in the urine until 9 hours after treatment. Peak excretion occurred in the second 24-hour period following the inunction.

The diminution in reactivity induced by hydrocortisone may help to explain, in part at least, the occasionally observed development of refractoriness of treated areas to prolonged application of the steroid.[7] Even more significant is the reappearance of inflammation, or "rebound," frequently recorded following cessation of treatment with hydrocortisone.[8] For this reason, combinations of the corticosteroids with other commonly used dermatologic modalities, including coal tar, are under investigation.[8] Welsh and Ede [7] have reported the successful use of combined hydrocortisone and coal or wood tars or their derivatives.

The experiences of the author are in agreement with other investigators that beneficial results with hydrocortisone seem to be limited to about two-thirds of the cases treated for atopic dermatitis or eczema.[9] A similar limiting factor is encountered with coal tar therapy.[10] Carney and Zopf[11] have stated that "it is impossible to relate clinical effectiveness in terms of statistics." According to Saunders and Davis,[10] "one cannot predict which dermatosis

†This work comes from the Newark Presbyterian Hospital.

will respond and which will not, since in comparable cases the treated skins failed to react in the same manner or degree."

It was felt that the use of coal tar combined with hydrocortisone, a combination that proved successful in the hands of Welsh and Ede,[7] is a rational one. As indicated by Gross and his colleagues,[12] coal tar probably affects keratoplastic action and also aids in healing of eczematous lesions. It was also considered that if there is any merit to such combined therapy (potentiation or additive effect), the two components should be used in relatively low concentrations. Hydrocortisone in 0.5 per cent concentration is somewhat less effective than the 1 per cent concentration.[13]

A STUDY was therefore undertaken to evaluate the effectiveness of a combination consisting of 5 per cent coal tar extract and 0.5 per cent hydrocortisone free alcohol in a vanishing cream base.*

The cream was supplied in one-half ounce tubes, and the patients were instructed to apply it by gentle massage to the affected area, until the cream vanished. Frequency of application was twice daily. The cream was given only to patients suffering from subacute and chronic dermatoses. The use of the words "cortisone" or "miracle drug" was avoided to rule out improvement on a psychologic basis.

A total of 210 cases were treated with the cream. Three failed to report for follow-up and are excluded, leaving a total of 207 cases with useful follow-up records. The table summarizes the results of treatment.

By comparison with previous experience, the combination of tar and hydrocortisone proved more effective than either medication alone, and was more effective than preparations containing more than twice the concentration of hydrocortisone alone.

In pruritic dermatoses and dermatitis venenata (chemical, oak or ivy), relief from itching was gratifyingly prompt and the inflammatory reaction was more quickly controlled. The response in anogenital pruritus was particularly remarkable: Patients refractory to all previous medication cleared completely after a few weeks of therapy.

Recurrent dermatoses, such as atopic dermatitis, neurodermatitis, anogenital pruritus and hand eczemas that had been treated on one

TABLE 1 — RESULTS OF TREATMENT WITH TAR EXTRACT-HYDROCORTISONE CREAM

DIAGNOSIS	No. of Cases	Degree of Improvement +++	++	+	O
Seborrheic dermatitis (scalp and other areas)	37	27	7	3	0
Psoriasis	4	1	1	0	2
Hand eczema	40	30	7	3	0
Pruritus ani or vulvae	32	19	9	3	1
Neurodermatitis	40	24	10	6	0
Nummular eczema	16	9	3	4	0
Duhring's disease	1	0	1	0	0
Dermatitis venenata	9	6	2	1	0
Atopic eczema	28	17	7	4	0
Totals	207*	133	47	24	3
Per Cent of Totals	100	64.2	22.7	11.6	1.4

Key
+++: Complete remission of all symptoms in 1 to 4 weeks.
++: Some improvement in one week; continued improvement thereafter but not to the point of clearance.
+: Prompt relief of itching and some improvement in other symptoms.
O: No improvement, except for relief of itching.
*: Three of an original 210 cases failed to return, and are excluded from the tabulation.

*Tarcortin® (Tarbonis Cream with Hydrocortisone), kindly supplied by Reed & Carnrick, Jersey City, New Jersey.

or more occasions previously with other agents, responded more quickly and often cleared completely on the combined therapy. So far in this series, recurrences have decreased. Thirty-one patients with refractory dermatitis have responded with clearance of symptoms on the combination (10 neurodermatitis, 12 anogenital pruritus, 9 atopic eczema).

IN GENERAL, the response to the combined therapy was more prompt and more sustained than with hydrocortisone alone. In the entire series there was no exacerbation, nor was there any evidence of irritation or sensitivity, even when the cream was used in intertriginous areas.

A total of 37 cases of seborrheic dermatitis of both the oily and dry types were treated. These involved the scalp and other areas. All showed some improvement, and 25 cases showed marked improvement within a week.

Hand eczemas are a major recurrent problem. Forty cases exhibiting this condition are included in this study. Each was given the cream as well as a soap substitute. All cases showed some improvement within a week, and 12 of these were markedly improved. These results were far better than those usually observed with other therapeutic agents.

Combined tar extract and hydrocortisone in low concentration appears to be an improvement over either agent alone. It is of interest that Welsh and Ede,[7] using combined tar-steroid therapy observed significant benefit in over 93 per cent of 402 cases treated. Even counting as failures those of our patients who experienced relief of itching only, our rate of benefit was 98.6 per cent. These findings represent a noteworthy advance over the usual experience.

In *all* cases the combination provided prompt relief. Results were more rapid and more pronounced than would have been expected from tar alone, or from hydrocortisone alone even in higher concentrations. There was virtually no irritation to the cream. My observation agrees with that of Welsh and Ede[7] that hydrocortisone lessens skin sensitivity to tar preparations. It also appears that, presumably because of the low dosage of hydrocortisone, together with the keratoplastic action of the tar, recurrences or "rebound" are avoided.

It is not intended to suggest that other definitive measures, directed against allergic, infectious, hormonal or psychogenic factors, are to be neglected in the treatment of dermatoses. It is believed that the relatively gently acting combination of tar and hydrocortisone may represent a potentiation of action that merits further investigation.

SUMMARY

1. A total of 207 cases of subacute and chronic dermatoses were treated with a greaseless, stainless cream* containing 5 per cent crude coal tar extract and 0.5 per cent hydrocortisone.

2. In *all* cases there was prompt relief, although in 3 patients relief of itching was the only improvement noted; these are counted as failures of therapy.

3. Complete remission of symptoms was observed in 132 cases (64 per cent); good results in 47 cases (23 per cent); and fair results in 25 cases (12 per cent).

4. Irritation, sensitization, the appearance of refractoriness, or the "rebound" phenomenon following cessation of therapy, were not observed in this series.

31 Lincoln Park

Bibliography will appear in author's reprints.

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Torsion of Fallopian Tube

When a young woman suffers from acute abdominal pain, it isn't always appendicitis, ovarian cyst, ectopic pregnancy or strangulated hernia. It could be—though it seldom is—a torsion of the tube. To the very meager collection of such cases, the authors here add one.

Torsion of the fallopian tube is a rare complication. Because it is so seldom diagnosed pre-operatively, the following case is added to the few already on record.

The first published case was cited by Blands-Sutton[1] in 1890. Schweitzer[2] published a case presenting torsion of a normal tube. Similar cases were described by Michael, Hansen, Scheid, and Neugenbauer[3] in 1918.

Predisposing factors include: (1) Adhesions and displacement of organs ;(2) Forces from without, such as trauma to the abdomen; (3) Extra-ordinary movement of the body such as in sports or dancing; (4) Growing tumor and (5) Intestinal peristalsis.

The predominating clinical feature is usually the onset of severe pain. The severity depends on the degree of torsion. It must be differentiated from appendicitis, ovarian cyst, salpingitis, lymphadenitis, strangulated hernia and ureteral disease. Diagnosis here was difficult because of the peculiar location of the pain. It radiated from the costo-vertebral angle downward to the pubic area, presenting an almost typical picture of a ureteral calculus. The symptoms were particularly severe because of the tremendous amount of torsion. The interference of the blood supply was to such a degree as to create gangrene.

This was a 15-year old well-nourished, well-developed girl. Three days before admission she felt intermittent, colicky pains in the left lower quadrant of the abdomen. Most of the time it radiated to the costo-vertebral angle. She also had uncontrollable nausea and vomiting. Pain was relieved by 100 milligrams of meperidine* for about one to two hours at best.

On admission to the hospital, she appeared acutely ill. She could not tolerate even the slightest touch on the abdomen. Family history was essentially negative. Menstruation had begun at the age of eleven, periods occurring every 28 days, lasting 5 to 6 days with no dysmenorrhea. After administration of meperidine, rectal examination was accomplished, revealing a mass in the left pelvic area; large, elongated and pointing upward. It was extremely tender and no attempt was made to move it in either direction. The entire abdomen was rigid throughout, particularly towards the left side.

Pre-operative diagnosis of twisted adnexa was made and she was operated on a few hours later.

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*Given in the form of the Winthrop-Stearns brand trade-named as "Demerol Hydrochloride."

A large amount of serosanguinerous fluid was found free in the abdominal cavity, similar to that seen in ectopic gestation. The entire small intestine in the vicinity appeared irritated. The right tube and ovary seemed normal though showing same discoloration as the intestines. Uterus was normal in size and position. The left tube looked like a large gangrenous mass about four inches long with variable thickness. A tumor was lying unattached, except by its pedicle which was twisted clockwise six times. The abnormal mobility here was due to complete absence of a meso-salpinx. The tube lay free in the abdominal cavity with no attachment to the shelving edge of the broad ligament. Complete left salpingectomy was done.

Gross Appearance: Left fallopian tube, but is scarcely recognizable as such. Along one aspect is a tubular structure, 9 centimeters long and averaging 9 to 15 millimeters in diameter. At the junction of the middle and distal third, there is a dilation measuring about 1.9 centimeter in diameter. What appears to be the lumen is filled with blood. Depending from this tubular structure is an irregular partly cystic mass, measuring about 4.5 centimeters in its greatest aspect. The entire specimen is markedly engorged and in some areas appears almost infarcted.

Appearance: Hemorrhage and vascular engorgement, connective and muscular tissue, consistent with infarct of oviduct.

335 Main St. (Ridgefield Park)

Radio-Active Chromium as a Red-Cell Signal

Red cell tagging with radio-active chromium is used to measure circulating red-cell mass and thus blood volume, to study the rate and site of red-cell destruction and to study circulatory dynamics. This report* concerns the use of 51-chromium in determining red-cell volume, measuring the viability of normal and abnormal stored red-blood cells and the tissue localization of chromium after red-cell breakdown.

In vitro, chromium taken into the red-blood cell becomes firmly attached to the globin portion of the hemoglobin molecule and the subsequent small amount of chromium exchange with plasma represents cell-washing effect. The discrepancy between cell-survival studies by radio-active chromium and by differential agglutination technics is explained by the escape of chromium from the red cell.

Estimations of total blood volume could be determined from the sum of plasma volume and red-cell volume. However, the cell-tag method appears more consistent since the intravascular localization of radio-activity when bound to red cells is assured. In the presence of constancy of body hematocrit, blood volumes calculated from red-cell tagging procedures appear the most accurate. The disadvantage of 51-chromium in blood volume determinations is the persistence of labeled cells in the circulation which makes repeated determinations increasingly difficult.

Radio-active chromium has many advantages for estimating post-transfusion cell survival. Small volumes of blood from a single donor can be given to multiple recipients and incompatibility dangers are minimized. Red-cell survival measurements in the human yielded half-time survivals of 26 days. Organ localization of radio-chromium suggests the apparent site of blood breakdown in certain hemolytic states. In the investigation of hemolysis, radio-chromium provides a means of determining the rate of blood destruction. Formulae are available for the conversion of half-time survival as determined by 51-chromium methods into mean cell-life and cell-destruction rates.

*Donohue, D. M. *et al.*: British Journal of Haematology, 1:249 (July 1955)

Eugene J. Luippold, M.D.
Boonton

Prednisone and Prednisolone in Refractory Pollinosis and Pollen Asthma *

Blessed relief for refractory cases of pollinosis is in sight if Dr. Luippold's success with prednisone and prednisolone can be consistently duplicated. The possibility that chance alone might have caused these good results has not been statistically appraised.

Effective therapy for the refractory cases of pollinosis and pollen asthma depends on sound scientific research. This is a three-stage process. It starts with biochemical research. Then comes application. The final step is to appraise effectiveness by the study of a sufficient number of patients to permit statistically valid conclusions.

This paper reports on 100 case studies of seasonal hay fever and asthma, treated during the summer and fall of 1955. These patients received inadequate relief from the usual methods of hyposensitization plus adjuvant drugs. They were then given prednisone and prednisolone. No attempt is made at statistical evaluation. As Bancroft [1] has warned, in allergy this is most difficult due to the variation in symptom reporting from one patient to another, and to the variation in environmental factors and pollen exposures.

Schwartz, *et al.*[2] reported a series of ragweed cases treated with cortisone. In these cases, a fixed dose of four 25 milligram tablets was given for a total period of fifteen days. Good results were reported. Sheldon, McLean and Mathews [3] treated severe asthmatics with prednisone with excellent results, but also at a fixed dosage level. Side effects were noted. Feinberg and Feinberg [4] similarly used prednisone in a variety of allergic disease. They felt that in most cases if a patient required less than 10 milligrams per day maintenance dose, he could probably get along without any further steroid therapy. In all of these reports, no other concomitant therapy was used.

Most allergists, in hyposensitization treatment, give the patient as high a dose of pollen antigen as is tolerated without the production of local or constitutional symptoms. Most patients receive a great deal of relief by such therapy, especially if an occasional antihistamine is made available for mild symptoms. There remains, however, a large group in whom the most intensive therapy, though ameliorating, still leaves the subject with most uncomfortable periods. It is this group which received the steroid therapy here reported.

*Presented at the Allergy Section, The Medical Society of New Jersey, Atlantic City, N. J., May 15, 1956. The prednisone and prednisolone were supplied by courtesy of Schering Company and Upjohn Company.

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2. Schwartz, E., *et al.*: Journal of Allergy 23:32 (January 1952)
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EACH patient under pre-seasonal, co-seasonal, or perennial treatment was asked at each visit to report any symptoms. If necessary, an attempt would be made to increase the amount of antigen tolerated without reaction. Usually one or more of the various antihistamines had been used by the patient in sufficient quantities to ascertain whether the patient would receive relief from them. If satisfactory relief was not forthcoming, the patient was given sixteen 5 milligram tablets of prednisone or prednisolone, with the instruction to take one tablet with each dose of the preferred antihistamine, as needed, up to a maximum of four doses a day. Medications were to be taken only when symptoms warranted, and not as a routine. No patients in this series had diabetes, tuberculosis, peptic ulcer, cardio-vascular or renal disease, or known psychotic tendencies.

No placebo was administered. The patients had all been given several antihistamines previously. Patients were not told the nature of the new tablet. It was offered as "just another tablet to try," rather than as an entirely different type of medication.

Only five patients, of the hundred in the series, reported no help from the addition of the steroid to the previous treatment.

Six patients required the regular use of one or more tablets daily for satisfactory relief. But *all of the remaining patients were enthusiastic about the combination.* In view of the varied conditions and circumstances, no attempt is made to calculate percentage figures. These would be meaningless. In most cases, the patients reported that one to four 5 milligram tablets (taken with their preferred antihistamine) had given immediate relief. This relief frequently lasted for several days. Only 6 of the remaining 89 patients needed more than their original amount of sixteen tablets to carry them through the entire pollen season. All of these used less than one refill amount of an additional sixteen tablets. There was no difference in the results from prednisone as compared with prednisolone, except in one case in which the prednisolone gave relief after the prednisone failed.

No side effects were noted except a euphoria attributed to the rapid relief of symptoms. There was no fluid retention, weight gain, moon face or hirsutism. These would hardly have been expected in view of the small dosages. No gastric symptoms were reported.

Three cases are cited to show the variety of clinical problem in which this therapy was effective.

CASE ONE

A 63-year old man had a history of severe ragweed hay fever for 34 years. Intradermal test showed a moderately severe reaction to ragweed 100 units per cubic centimeter. Despite this, his tolerance was very high. In 1951, and each year thereafter he received 16,000 protein units of ragweed, *plus* 18,000 units of protein precipitated ragweed with only fair results. In 1955, on 16,000 units each week during the ragweed season, symptoms were severe, despite the regular use of supplementary antihistamines.

On August 26, he was given 16 prednisone tablets. On that day, he took three tablets with three of the previously used antihistamines. That evening, he phoned to report that he was completely relieved. The remaining 13 tablets, taken at two to four day intervals, were sufficient to give almost complete relief throughout the remainder of the ragweed season.

CASE TWO

A 39-year old man had chronic year-round allergies requiring at least one antihistamine daily throughout the year, and three to four per day for even partial relief during the ragweed season. Previous attempts at hyposensitization had resulted in severe constitutional reactions at a very low dosage level. Intradermal tests showed marked sensitivity to ragweed 100 units per cubic centimeter. From 1946 to 1952 he had taken no treatment except antihistamines because of his fear of the constitutional reactions. In 1953, he tried oral cortisone, but this gave him a sensation of numbness in his head. ACTH-gel, however, gave considerable relief. In 1954 he again tried hyposensitization. The maximum tolerated dose was 7 protein units, and this was only tolerated if 2 milligrams of Chlor-Trimeton Maleate† was added to each injection. Results were poor. Additional relief was finally obtained by ACTH-gel. In 1955, he was better than ever before on a maximum dose of 10 units until August 26, when severe symptoms recurred. One prednisone and one long-acting antihistamine per day thereafter gave complete relief, and after seven days was needed only every two to three days. Sixteen tablets carried the patient through the entire remaining ragweed season.

†This is Schering's registered tradename for their brand of Chlor Phen Pyridamine Maleate.

CASE THREE

A 48-year old woman had grass hay fever of many years' duration. Timothy 100 units per cubic centimeter intradermally gave mild reaction; 1000 units a very severe one. Tolerance by subcutaneous injection was limited to 15 units, with poor symptomatic relief. The following year, intradermal therapy was used with much better results. This method was utilized each year thereafter. Always there were a few bad days at the height of the grass pollen season. In 1955, after six tablets of prednisone, there was complete relief, although the pollen count was still high and remained so for two weeks after the initial dose of the steroid.

CONCLUSION

THIS is a report of successful results in a large majority of difficult cases. If confirmed by further investigation, it suggests a simple method of handling that fairly large group seen in every allergist's practice which still needs help beyond that given by the usual methods. By combining the beneficial effects of hyposensitization and antihistamines with a small amount of steroid treatment, the dangers of the latter alone are largely avoided. The amount needed for such relief in all of the reported cases was so small that no toxic reactions were noted. No precautions were found to be necessary beyond the normal screening of the patient. Nonetheless, it is still felt advisable that the use of the steroids, however safe the new ones may be, should be limited to those cases where the usual methods of hyposensitization are inadequate.

West Main Street

Steam Kettle Better Than Humidifier?

The good old steam kettle works better than a mechanical humidifier for treating a childhood respiratory disorder. So writes Dr. Abraham Friedman in the Nov. 1955 A.M.A. *Archives of Otolaryngology*. He thinks that the steam kettle is better because it can produce more moisture than a cold-air mechanical humidifier, the now generally accepted apparatus. Moist air helps prevent blocking of breathing passages.

Dr. Friedman points out that in breathing, the air enters the respiratory tract at room temperature and humidity. On its way down the air absorbs moisture. It is exhaled at body temperature and saturated with water. The difference in temperature and humidities between the air inhaled and exhaled results in a continuous loss of water from the respiratory tract.

In acute respiratory disease, the loss is speeded up and the breathing passages eventually may be blocked by the formation of a dry crust on the membranes. The drier the inhaled air, the more water it absorbs from the membranes, thus increasing their "drying out."

To prevent obstruction, the air breathed in must be as moist as the air breathed out. This means that the temperature and humidity of the air inhaled should be approximately equal to the temperature and humidity of the air exhaled.

Since there is a ceiling on the amount of water air will hold at a specific temperature, the air temperature must be raised to increase water content. The mechanical humidifier may raise water content, but the low-temperature air cannot hold as much water as high temperature air would, he said, adding that a steam kettle accomplishes both things.

A. I. Friedman, M.D.

Hackensack

Portal Cirrhosis: Pathologic Physiology*

In a review of 60 cases of portal cirrhosis, Dr. Friedman found that 52 had a history of alcoholism, but fewer than half had visible jaundice. In spite of the usual gloomy prognosis there were four patients where the process was reversed.

The word "cirrhosis," first used by Laennec, is from the Greek for "yellowish" color. Portal cirrhosis is a chronic progressive destructive lesion of the liver associated with connective tissue reaction and fibrosis. It is essentially a diffuse interstitial hepatitis. The patient usually survives the first attack, with regeneration of liver cells and formation of a nodular parenchyma.

ETIOLOGY

Portal cirrhosis appears to be primarily a deficiency disease with syphilis, alcohol, or toxic states as secondary offenders. Protein malnutrition, specifically various factors of the B complex appear to be the important missing substances that induce the toxic effects of ethanolism. However, the relationship in man is still obscure. In the experimental animal fatty liver cirrhosis yielding to fibrosis and hepatoma develops with a diet deficient in lipotrophic factors.[1] The latter substances, methyl-containing amino acids like methionine and choline, decrease the rate of fat deposition and remove excessive liver fat. In addition, these diets must be deficient in B_{12} and in the folic acid citrovorum factor. Unfortunately, in humans the ineffectiveness of lipotrophics is well-known. Studies in Africa and in other areas where human malnutrition is severe, have revealed a nutritional liver disease, "Kwashiorkor," prevalent among children. It is characterized by retardation in growth, muscle-wasting, skin changes, ascites, fatty infiltration of the liver as well as adenomatous changes in the pancreas.[2] The disease is presumed to lead to portal cirrhosis and hepatoma in the adult. Except for the pancreatic changes, "Kwashiorkor" bears a remarkable similarity to the sequence of events in portal cirrhosis. However, there is no conclusive proof that protein defect is the only cause of "Kwashiorkor." There is apparently no lack of amino acids in these patients.[3] Milk, particularly human milk although low in protein is one of the best means of preventing and curing the disease. In temperate climates, nutritional fatty liver cirrhosis is most frequent in alcoholics. Probably the ingestion of alcohol produces an increase in the requirements of labile methyl groups rather than a simple deficiency of amino acids.[4] At the same time, the protein-sparing action of the high caloric energy in alcohol may be another important factor depressing available serum protein. Balance studies however, revealed no deviations from the normal nitrogen absorption or utili-

*From the Medical Division of Bergen Pines County Hospital, Paramus, N. J., G. Barton Barlow, Director. This paper was read before the New Jersey Gastroenterologic Society, February 13, 1956.

zation of amino acid tolerance in cirrhotics.[5] The excretion of all the essential amino acids was normal. We just do not know all the factors involved in the development of portal cirrhosis. The lack of adequate correlation between pathologic physiology and clinical and laboratory data is evident.

CLINICAL FINDINGS

SIXTY patients with portal cirrhosis were reviewed. Forty-six were males. Fifty-two gave a history of alcoholism of moderate or severe degree. One had a history of severe malnutrition. He had been a prisoner in a concentration camp in Germany for six years. Symptoms of portal cirrhosis developed four years following his release. He subsequently died of primary carcinoma of the liver (hepatoma). The clinical findings are listed in the table.

Most patients with cirrhosis, observed for the first time, do not have visible jaundice. The degree of jaundice, when present, is a good measure of the extent of parenchymatous disease. The jaundice is essentially due to failure of the liver to excrete bilirubin. Intrahepatic obstruction is incomplete, but one must be alert to the fact that complete obstruction of biliary radicles with absence of urobilinogen from the stools may occur in the acute phases of the disease. In part, also, jaundice is presumed to be due to rapid destruction of red blood cells. The red blood cells of some patients with cirrhosis have a shorter life span than in normals. This is true even though a positive Coombs test is rarely found. On the other hand portal hypertension is more prominently related to the fibrotic process in the cirrhotic and is clinically obvious when collateral circulation between the portal and caval systems is visible on the anterior abdominal wall. Other important anastomotic channels exist between the superior and inferior hemorrhoidal veins and the coronary vein of the stomach with the intercostals and azygos around the esophagus. The development of portal hypertension is presumed to be a combination of factors. These include: connective tissue proliferation, accentuated by diminished portal blood flow and a remarkable patency of the hepatic artery-portal vein connections, an arterio-venous shunting both within the lobule and outside of it producing in reality an Eck fistula, *i.e.*, communication between portal vein and inferior vena cava.[6] These arterio-venous anastomoses alter their caliber under adequate stimuli in the normal liver. Because of extensive fibrosis in the cirrhotic liver they can no longer act as control valves and the more direct hepatic arterial flow contributes to the elevated portal pressure.

60 PATIENTS WITH CIRRHOSIS

54	Hepatomegaly	
29	Ascites	
28	Jaundice	
25	Hemorrhage	
	12	Hematemesis
	5	Epistaxis
	4	Melena
	4	Gingival bleeding
17	Collateral circulation	
	15	Abdominal & Thoracic veins
	6	Hemorrhoids
20	Hormonal abnormalities	
	18	Spiders
	6	Palms
16	Acute and chronic brain syndrome	
12	Smooth, red tongue	
8	Splenomegaly	
7	Neuropathies (peripheral)	

Ascites is one of the more prominent and most common complications of liver disease. While the causes are multiple, one of the chief factors is portal hypertension. Nevertheless severe portal hypertension may exist without ascites though all the other manifestations of high portal pressure are present. Reduction in serum albumin due to the liver's failure to synthesize this protein leads to a lowering of the osmotic pressure of the plasma. This combination of decreased colloid osmotic pressure and high portal pressure usually leads to ascites as fluid leaves the portal system. In addition an increase of anti-diuretic hormone has been found in the blood and urine of patients with ascites. The failure by the liver to inactivate A.D.H. of the posterior pituitary[7] and the retention of sodium and water due to increase of circulating adreno-cortico steroids

(aldosterone) tend to prevent normal diuresis in cirrhotics.[8] The absence of sodium in the urine of cirrhotics on a normal sodium intake leads to the conclusion that the defect in sodium excretion may be of primary concern in ascites. Clinical evidence confirms this hypothesis. Water retention and delayed water excretion may be the first sign of compensated or latent cirrhosis [9] when all other laboratory findings are normal.[10] It is suggested that some cirrhotics suddenly cease to produce ascitic fluid following repeated parecenteses because of the accelerated disposal of anti-diuretic materials.

THE source of the ascites appears to be related to intrahepatic venous hypertension rather than to splanchnic hypertension. In animals, occlusion of the hepatic veins has shown that the primary source of the ascites is transudation from the surface of the liver itself. These experiments correlate well with the fact that the most troublesome ascites is associated with the Chiari syndrome in which the cause is obstruction of the hepatic veins.[11] Child [12] believes that the source of ascites in portal cirrhosis in man is the liver and that the liver, in a sense, weeps fluid.

Hemorrhage is caused by a combination of mechanical factors induced by portal hypertension and a deficiency in blood coagulation due to the diseased liver. Its serious effects are due to shock and to the further decompensation of an already seriously compromised organ. Severe hemorrhage may usher in jaundice, ascites and hepatic coma. Spiders are important clinical stigmata though they may occasionally be found during pregnancy, hepatitis or in normal subjects. Multiple spiders are usually pathognomonic of cirrhosis. The mode of production of these dilated arteriolar loops is unknown. The occasional finding of endocrine disturbances (such as gynecomastia, testicular atrophy, loss of sex-linked hair and palmar erythema) seems to favor a hormonal origin.[13] Efforts to produce spiders by feeding estrogens have been equivocal. The possibility has been raised that spiders may also be present in the mucosa of the intestinal tract and a source of bleeding.

Macrocytic anemia is often found in portal cirrhosis. In this series, however, in 12 per cent, studies of B_{12} absorption have revealed no deficiency of this vitamin. Like the smooth, red tongue, these findings reflect the nutritional deficiencies in advanced cirrhotics.

The incidence of duodenal ulcer is reported as much higher in portal cirrhosis than in the general population where it is about 5 per cent. But duodenal ulcer was found in only one of these 60 patients—an incidence of 1.6 per cent. In one patient a gastric ulcer was discovered at postmortem. He had been operated on because of several massive episodes of hematemesis. A porto-caval shunt was performed. He continued to bleed and finally exsanguinated. The gastric ulcer was presumed to be an important cause of hemorrhage.

HYPERTENSION for the appropriate age groups has a much lower incidence in portal cirrhosis than in the general population. Hypertension in patients who develop portal cirrhosis may disappear as the liver disease progresses. One patient in this series was admitted six times during one year, mostly for acute alcoholism. His blood pressure dropped from 224/120 to 156/66 as the liver disease advanced. In the 60 patients, eight had blood pressures over 150 systolic or 100 diastolic or both. Three of these presented acute or chronic brain syndrome, two a pyelo-nephritis and one each neurosyphilis, diabetes and arteriosclerotic heart disease. Although renal disease was found in eight additional patients there was no associated hypertension. One can conclude that hypertension in portal cirrhosis with no associated pathology is uncommon and that hypertension in association with renal disease in cirrhotics is not usually due to the renal disease.

The frequency of central and peripheral nervous involvement in cirrhotics has not been much emphasized. But more than 10 per cent of these patients showed peripheral neuropathy, usually due to thiamin deficiency with muscle cramps and tenderness and with loss

of deep tendon reflexes. Acute or chronic brain syndrome with manifestation of toxic psychoses were seen in 25 per cent of the patients. Nicotinic acid administration is useful in controlling these manifestations of a central nervous system disorder (deficiency).

Much of the current literature on liver disease concerns ammonia intoxication and its relationship to encephalopathy (ammoniagenic coma). The source of the ammonia is considered to be the enzymatic action of urea-splitting organisms in the intestine. Central nervous system disturbances have been induced in patients with porto-caval shunts just as they were originally produced [14] in the experimental animal following an Eck fistula by feeding high protein diets or nitrogenous substances. Because ammonia levels are not consistently elevated in coma, McDermott [15] developed the concept that L glutamic acid (by combining with ammonia to form glutamine) would be useful in cases where the primary cause of decompensation was the sudden introduction of an overwhelming amount of nitrogenous substances, like blood, into the intestinal tract. Results, however, have been disappointing. Contrary to the generally accepted opinion a recent report reveals that the administration of massive doses of ammonium chloride failed to produce any untoward effect in patients with severe cirrhotic disease.

Although protein deficiency may be an important factor in cirrhosis it does not follow that a high protein diet is necessarily the most beneficial. The general tendency to prescribe high protein diets in patients with cirrhosis requires re-evaluation and cautious application. I previously mentioned the effects of high protein feedings on patients with porto-caval shunts who became psychotic with electro-encephalographic changes and stupor. Improvement occurred on a low protein diet but the psychosis recurred when a high protein diet was reinstituted. In patients with severe liver disease or those with early cerebral manifestations, administration of large quantities of protein has precipitated hepatic coma. It is probably safer to employ a maximum of 100 Grams of protein per day in the average patient than the high protein diet routinely. The greater the hepatic decompensation the more closely should the protein intake approach a milligram-per-kilogram-a-day and thereby reduce the functional load on the liver.

Reversibility of the disease process was observed in four patients who presented severe abnormalities in serum albumin and globulin as well as a 4-plus cephalin flocculation. During their hospitalization (and in one patient within a period of 6 weeks) there was a striking reversal of laboratory findings revealing a significant physiologic improvement. This ability on the part of the liver to revert to a normal physiologic pattern with adequate therapy even though pathologic stigmata remain is the one optimistic note that should sustain the patient and the physician in the morbid picture of the usual downhill course of portal cirrhosis.

405 State Street

Bibliography will be included in author's reprints.

State Activities • • •

1956-1957 COMMITTEE CHAIRMEN

Annual Meeting	Jerome G. Kaufman, Newark
Cancer Control	George P. Koeck, Newark
Chronically Ill	William H. Hahn, Newark
Emergency Medical Service, Civil Defense	R. Winfield Betts, Medford
Finance and Budget	David B. Allman, Atlantic City
Hearing and Speech	S. Eugene Dalton, Ventnor
Honorary Membership	Aldrich C. Crowe, Ocean City
Industrial Health	Ronald F. Buchan, Newark
Legislation	H. Hale Hollingsworth, Clifton
Maternal and Infant Welfare	John D. Preece, Trenton
Medical Defense and Insurance	J. Wallace Hurff, Newark
Medical Education	Gerald I. Cetrulo, Newark
Medical Practice	Irving Klompus, Bound Brook
Medical Student Loan Fund	F. Clyde Bowers, Mendham
Mental Health	Robert S. Garber, Princeton
Physicians Placement Service	Marcus H. Greifinger, Newark
Publication	J. Lawrence Evans, Jr., Leonia
Public Health	Samuel Blaugrund, Trenton
Public Relations	Samuel M. Diskan, Atlantic City
Rehabilitation	Elmer J. Elias, Trenton
Revision of Constitution and By-Laws	Louis F. Albright, Asbury Park
Routine Health Examination	Robert E. Verdon, Cliffside Park
School Health	Neil Castaldo, Cranford
Scientific Exhibit	William W. Hersohn, Atlantic City
Scientific Program	Edward E. Seidmon, Plainfield
Vision	A. M. K. Maldeis, Camden
Welfare	Kenneth E. Gardner, Bloomfield
Widows and Orphans of Medical Men	Harry H. Farb, Newark
Woman's Auxiliary Advisory	L. Samuel Sica, Trenton
Workmen's Compensation	Frederick G. Dilger, Hackensack

In subsequent issues of THE JOURNAL the roster of the committee chairmen will be found on Advertising Page 3A.

Trustees Meetings

May 12, 1956

On May 12, the Trustees met in Atlantic City. The Board heard the report of the Special Committee on testimony in malpractice cases. This recommended establishment of a joint committee of the Medical Society and the Bar Association. This joint committee would be available to weigh the merits of any proposed malpractice claim. The matter was referred to the House of Delegates.* Also referred to the House was a resolution calling on State Department of Institutions and Agencies to modify its policy of limiting the amount of medical care available to indigent clients in nursing homes.* The Board approved an interpretation of the status of alternate delegates by recommending the following addition to the By-Laws: "In the absence of a delegate, any alternate delegate who is available shall be eligible to serve."

The Board recommended a contribution of $25,000 to the American Medical Education Fund.* The Trustees also voted to borrow, temporarily, from the Treasurer's surplus funds, an amount not to exceed $3000 for the Medical Student's Loan Fund.

Report was made of the results of the mail poll on the extension to physicians of social security coverage. Of the 6060 ballots mailed out, 3422 were returned. Of these 1543 favored and 1869 opposed the compulsory extension of social security coverage. There were also 21 ballots where the choice was not noted. Of valid ballots, 54 per cent were opposed and 46 per

*This action was subsequently approved by the House of Delegates.

cent favored such extension of social security. The Board then heard the report of the committee to study the Rahway Plan and adopted the committee's report. That report was:

This committee recommends that although The Medical Society of New Jersey should not disapprove the Rahway Plan neither should it approve it for by its approval the public might be led to believe that the Rahway Plan is equal in benefits to the benefits of the Blue Cross. This committee believes:

1. That state approval should be withheld because the Rahway Plan is not a state-wide plan but is localized in one section of the state surrounding Rahway and therefore they should ask approval of the County Medical Society only not The Medical Society of New Jersey.

2. That the coverage of the Rahway Plan is complete coverage only in the 60 affiliated hospitals. Even in those 60 hospitals, it is on an indemnity basis after the first 21 days of contract. It has always been the policy of The Medical Society of New Jersey not to approve indemnity plans. This is an indemnity plan with most hospitals throughout the state; and even in the 60 hospitals in which it is supposed to give complete coverage after the first 21 days of hospitalization.

3. That the Rahway Plan also offers an indemnity plan in which the patient has to pay the first $5 of cost on every day from admission to the hospital. This is an indemnity program which does not give full coverage.

4. That if The Medical Society of New Jersey were to approve the Rahway Plan which is in large part an indemnity plan then all other insurance companies offering indemnity plans should be approved. The best possible coverage that a subscriber can get is now being written by the New Jersey Blue Cross which gives the patient complete coverage in semi-private accommodations in 250 hospitals throughout New Jersey. The committee, therefore, feels that approval of the Medical Society should be limited at this time to the New Jersey Blue Cross and should not include the Rahway Plan.

The Board approved the 1956-7 contract with the Veterans Administration. It reappointed Dr. Frederick G. Dilger as our representative to the Crippled Children's Commission. The Board directed the editors of the JOURNAL and of the *News-Letter* to publish a reading notice to the effect that the Society had available for distribution to interested physicians, two pamphlets on industrial medicine. One was on estimating the loss of visual efficiency. The other was a procedural guide for industrial nurses.

The Trustees authorized the incoming President to appoint the physician-personnel of a joint Medical Society-Hospital Association Committee on Disaster Control Planning.

The Board heard and approved a report by the Blood Bank Commission. (Published on page 385 of this JOURNAL). The Trustees authorized Dr. Betts, as Chairman of our Committee on Emergency Medical Service to attend the American Medical Association's Council on National Defense session in Chicago this summer.

The Board unanimously adopted the following resolution honoring Dr. Sommer:

WHEREAS, Doctor George N. J. Sommer of Trenton has since 1896 been a member in good standing of The Medical Society of New Jersey, and

WHEREAS, his years of membership have been years of distinguished service, during which he advanced to the presidency of the Mercer County Medical Society and The Medical Society of New Jersey, and

WHEREAS, by his attainments as a surgeon and his services as a citizen he has well deserved the gratefulness of both his colleagues and his fellowmen, and

WHEREAS, now, in his 82nd year, he has been admitted to the status of emeritus membership in The Medical Society of New Jersey, therefore be it

RESOLVED, that The Medical Society of New Jersey, through its House of Delegates, hereby acknowledge its profound indebtedness to and deep affection for Doctor Sommer for the example and profit of his life to medicine and to mankind.

The Board also adopted special votes of appreciation to Dr. Butler, Dr. Lance, Dr. Costello and to Mr. John Thompson.

May 15, 1956

The Trustees held their reorganization meeting in Atlantic City on May 15, 1956. Dr. Blaisdell was re-elected chairman of the Board. Dr. Ware was elected secretary of the Board. The personnel of the Society's staff were all reappointed at salaries provided in the 1956-7 budget. The Board authorized the President to establish a Special Committee on Mental Health. Drs. Duffy and Ware were named as representatives to a conference on the emotionally disturbed child scheduled for June 8. The Trustees authorized Dr. McCall, Mr. Nevin, the President, the President-Elect, and the Secretary to attend the June 15 Chicago

session of the American Medical Association. The Board adopted a resolution thanking Dr. Kaufman and the Annual Meeting Committee for their labors in producing the highly successful 1956 Annual Meeting.

The Board approved the new agreement with the State Medical Journal Advertising Bureau. The editor, speaking for the Publication Committee, said that the Publication Committee could not approve of the proposal to devote an entire issue of the JOURNAL to industrial health, and could not approve of re printing in the JOURNAL certain previously published AMA reports on industrial health. The Trustees agreed with the Publication Committee.

The Board invited AMA delegates to attend all meetings of the Trustees during the year. The Board also approved of the naming of Dr. Greifinger, Dr. Kump and Dr. McCall to study the proposal of the International Ladies Garment Workers Union to set up a health insurance plan in New Jersey. Also approved, was the naming of Dr. George Ginsberg to the 1956 Diabetes Detection Drive.

The Board authorized the President to appoint a special committee on revision of the Constitution and By-Laws. The following committee was appointed:

Dr. Louis F. Albright, Chairman
Dr. Albert B. Kump
Dr. H. H. Hollingsworth
Dr. Joseph M. Gannon
Dr. John F. Kustrup
Dr. William E. Dodd
The President, the Executive Officer and the Editor, *ex officio*
The Legal Counsel, Advisor

STATE-WIDE BLOOD BANK PROGRAM

These recommendations, prepared by the Blood Bank Commission, were approved by the Trustees on May 12, 1956.

In compliance with principles set forth in previous recommendations, approved by the Board of Trustees, the Blood Bank Commission has explored further the question of coordination of activities of blood banks throughout the state both for purposes of routine hospital practice and for civil defense planning. As a result of decisions reached at its meeting of April 15, 1956 the Commission recommends:

1. That The Medical Society of New Jersey instruct each component county society to bring to completion or take the initiative in organizing an energetic program of blood bank expansion within each county to the end that maximum efficiency be achieved in blood donor recruitment and in all technical procedures involved.

2. That sponsorship of such a program take into account all the varied elements in the population represented in the county and endeavor to obtain the cooperation and participation of representatives not only of the medical profession but also of various civic groups, industry (both management and labor), hospitals, and voluntary organizations having similar interests.

3. That each county society designate one of the blood banks in its county as the County Blood Bank to serve as its regional representative in accordance with the action of the Board of Trustees, May 22, 1955. In this action the Board approved the policy of integration of all blood banks in each region about a central headquarters in the interest of development of uniform standards of blood collection to permit interchange of blood within each region and, if practicable, with other regions for civil defense and other purposes. Each County Blood Bank (or regional blood bank for two or more counties where it is impracticable to have one blood bank for each county) should be responsible to the county medical society and be administratively independent of any one group or hospital in the county. Wherever practicable, it should have its own staff, facilities, and building, although in the interests of expediency it may be necessary as a temporary measure for the county blood bank to be housed in one of the hospitals. The policy should be set forth clearly that insofar as such a blood bank functions as an agent of the county medical society it should preserve full administrative independence of any hospital.

4. That while preserving its local autonomy in all the aforementioned respects, each county medical society maintain the closest possible communication with the Blood Bank Commission so that, in the interests of uniform standards, economy, and efficieney of operation the common experience of all regions of the state may be pooled and made available to each other. As an advisory and consultative body the Blood Bank Commission, representing not only the State Medical Society but also the New Jersey Society of Clinical Pathologists holds itself ready to assist each county in all possible ways. These will include participation in planning, assistance in establishment of inter-regional exchange policies, and assistance in setting up teaching programs in each regional (county) blood bank. Such teaching programs will be conducted by members of the New Jersey Society of Clinical Pathologists with the assistance, where practicable, of the State Department of Health, to provide refresher courses for existing blood bank personnel and primary training of suitably qualified volunteers in technics of blood collection and processing which will be in keeping with the standards of the National Institutes of Health.

5. That at the earliest possible moment each regional blood bank establish a county registry of blood collection agencies, hospital and other, so that in the event of a major disaster, a roster can be made immediately available of all potential sources of blood. Included in such a registry should be information on the estimated total blood drawing capacity per hour of each agency, the total capacity per hour of blood drawn in each such agency licensed by the N.I.H.,* the total number of available technicians trained in blood typing and crossmatching, and the names, location and types of all donors currently on file in the area.

SYLVAN E. MOOLTEN, M.D.
Chairman, Blood Bank Commission

*N.I.H. means National Institutes of Health.

The New Jersey Adoption Law†

Physicians may, unwittingly, run afoul of the current New Jersey Adoption Law. Family doctors, obstetricians, gynecologists, pediatricians, psychiatrists and general practitioners, are, from time to time, asked to "obtain" a child for adoption, or in some manner to assist in developing an adoption. The following data are drawn from an article by the Executive Director of the Children's Aid Society of Orange. This is adapted from the February 1956 issue of the *Bulletin* of the Essex County Medical Society, through the courtesy of Dr. Frank Rosen, editor of that *Bulletin*:

The current statute provides that anyone placing, offering to place or *in any manner* assisting in the placement of a child in the home of any person for the purpose of adoption is guilty of a misdemeanor. This does not apply to a licensed adoption agency. The exception is the natural parent who must place the child directly with the adopting couple (no intermediary). A physician must *not* serve as intermediary. By "intermediary" is meant anyone who places, offers to place or in any manner assists in placing a child for adoption. This action is specified as a crime under our law. If the receiving or paying of money is involved, the crime becomes a high misdemeanor. The punishment for this type of crime is a fine up to $2000 or 7 years' imprisonment.

In direct placements by the parent, the legal proceedings must now be instituted immediately upon the child coming into the home of the adopting couple. Formerly, a year elapsed before the proceedings were brought to the Court's attention.

In such case, the custody of the child is granted to the Court which has power to remove the child from the home of the applicants if appropriate. The Court at this point directs supervision of the home by an accredited agency for the period of a full year.

It contains a provision that in adoption placements not through agencies, the natural parents be notified of the preliminary hearing and afforded an opportunity to contest the application if they wish. Written consents by the parents are no longer recognized and will have no effect on the adoption procedure. The great risk in private placements from the point of view of the prospective adopting couple occurs not only from the possibility of a change of mind of the natural parent but also that at any time during the year, the Court can remove the child summarily from the adopting home.

According to a recent bill signed by the Governor in November, 1955, surrenders of infants by their natural parents *to accredited agencies* are now irrevocable except at the instance of the agency; or except for duress, fraud or error.

In addition to the material above, our readers might be interested in this extract of a memorandum issued by the State Board of Child Welfare:

Prior to 1954, extinction of parental rights (in adoption) was accomplished by the execution of consents. Under the present statute, termination of parental rights is provided for by service on persons having custody and judicial decision at the time of preliminary hearing. As a consequence, consents are effective and required only in the following cases: (1) by an approved agency which has placed the child; or (2) by the next friend appointed by the court and (3) by a husband or wife whose spouse is adopting the child. This situation normally involves adoption by a stepparent, and a definite statement of the relationship will clarify the application.

The present adoption statute simplifies and clarifies the child's legal relationships to the natural and adoptive parents subsequent to the adoption. *All rights of inheritance between the child and his natural parents are terminated.*

Under the older law, there was provision for only one hearing. This took place after child had

†See editorial page 350 of this JOURNAL.

been in the new home a year. The present law provides for two types of hearings: (1) the preliminary hearing which precedes the child's residence in the plaintiff's home and is concerned with termination of parental rights; (2) the final hearing which follows the period of residence and is concerned with approval of the adoption relationship.

In most cases only one appearance before the court will be required as follows:

A preliminary hearing is always required unless the child has been placed in the home of the plaintiffs with the approval of an approved agency. In such cases the matter goes directly to final hearing.

When the child is being adopted by a brother, sister, aunt, uncle, grandparent or stepparent, the court may proceed immediately from the preliminary to the final hearing. However, the court may require an interim period of supervision by a next friend if the child's interests would be better protected.

When the report of the next friend recommends the adoption, the court may dispense with the final hearing.

When a particular situation requires a preliminary hearing, an approved agency is called upon to make an investigation. The agency may also be called upon to act as next friend to advise the court concerning the child's adjustment in the prospective adoptive home.

What do you do if a patient or friend asks you about an adoption? The answer is simple; refer him to an approved adoption agency. Do *not* give him the name of any woman who has (or expects to have) a child to adopt out. Do *not* give a mother the name of a couple interested in adopting a baby. Though your intentions are noble, this could be considered a black market procedure. Don't do it. Instead give the parties the name of an approved adoption agency.

To get the name of an approved agency, phone the State Board of Child Welfare. You'll find their offices in Atlantic City, Bridgeton, Camden, Elizabeth, Hackensack, Jersey City, Morristown, Newark, New Brunswick, Paterson, Red Bank and Trenton.* There is one near you.

If you expect to have frequent need for this information, you might cut out the following list of approved agencies. Remember though (a) these list change frequently, and (b) Many of these agencies limit their services to certain areas, religious groups, or children of special status.

Atlantic City: State Board of Child Welfare*

Bridgeton: State Board of Child Welfare*

Camden: Catholic Aid Society, 523 Haddon Avenue; *also*, State Board of Child Welfare*

Elizabeth: Family and Children's Society, 40 North Avenue; *also*, State Board of Child Welfare*

Hackensack: Conklin Child Welfare Home, 125 Essex Street; *also*, State Board of Child Welfare*

Jersey City: Lutheran Welfare Association, 93 Nelson Avenue; *also*, State Board of Child Welfare*

Long Branch: Family and Children's Society, Garfield Court

Montclair: Family and Children's Society, 60 South Fullerton Avenue

Morristown: State Board of Child Welfare*

Newark:
Catholic Charities, 31 Mulberry Street
Children's Aid Society, 241 Springfield Avenue
Jewish Child Care Association, 15 Lincoln Park
State Board of Child Welfare, 1060 Broad Street

New Brunswick: State Board of Child Welfare*

Orange: Children's Aid Society, 439 Main Street

Plainfield: United Family Society, 703 Watchung Avenue

Paterson:
Catholic Charities, 10 Jackson Street
Jewish Social Service, 390 Broadway
State Board of Child Welfare, 35 Church Street

Trenton:
Catholic Welfare Bureau, 55 North Clinton Ave.
Children's Home Society, 929 Parkside Avenue
State Board of Child Welfare, 600 Artisan Street

*See local telephone book, under "New Jersey, State of—Board of Child Welfare."

Industrial Health Pamphlets Available

On request, you may obtain from the Executive Offices, two pamphlets on industrial health. One is *Estimation of Loss of Visual Efficiency*. The other is entitled *Guiding Principles for Industrial Nurses*. If interested, write to Executive Offices, The Medical Society, 315 West State St., Trenton 8, N. J. These pamphlets were prepared by the Council on Industrial Health of the American Medical Association.

Letters to The Journal • • •

Prices of Drugs

Dear Editor:

In your editorial on "High Priced Drugs," you raised an important point. Since nobody wants to get sick, expenses for drugs are bound to cause complaints. Therefore it is only natural to look for a scapegoat and we are easily tempted to blame advertising for the cost of drugs.

Any fair-minded observer will agree that in drug advertising, as in most fields, there have been occasional excesses. But let's not overlook the positive contributions of advertising, as shown by a simple example: In 1906, an automobile cost over $6000. In 1956, we can buy a far better car for $2500. Why? Largely because advertising has created a mass market which permits far more economical production.

Similarly, the cost of penicillin, cortisone, vitamins, antibiotics, hormones and many other drugs has dropped substantially during the past few years. Several factors have been responsible for these price cuts; but prominent among them is mass production made possible by extensive promotion.

The truth is that advertising accounts for only a small part of the retail price of most drugs. If we eliminated it the immediate saving to the patient would be negligible; but in the long run the effect might well be more expensive and less efficient distribution. Today new drugs are being introduced in rapid succession and advertising provides one of the most efficient and economical methods of keeping the physician posted.

Surely advertising is an integral part of our free competitive system—a system which has enabled the United States to attain an unprecedented standard of living and medical care.

Sincerely

ROBERT A. HARDT, *President*
National Pharmaceutical Council
New York 20, N. Y.

Obituaries • • •

DR. IDA FROHWEIN

Dr. Ida Frohwein, formerly the senior physician in the Elizabeth (N. J.) Child Health Department, died on May 27. Dr. Frohwein was 77 at the time of her death.

A native of Jersey City, Dr. Frohwein was graduated from the Women's Medical College of Philadelphia in 1901. After interning in Philadelphia, she went into private practice in Jersey City, and later moved to Elizabeth. There she married Richard Frohwein, proprietor of Elizabethtown's oldest pharmacy. In 1919, Dr. Frohwein gave up private practice to devote herself to the public health aspects of child hygiene. By 1951 she had advanced to senior child hygiene physician in the Department. For years she was active in the Union County Medical Society and became an emeritus member in 1952.

DR. FREDERIC H. SEWARD

In 1954, the Morris County Medical Society met to do honor to Dr. Frederic H. Seward, then 76 years old, the dean of Morris County practitioners. Dr. Seward died on May 10, 1956. He was born in Morris County—in Chester—during the Presidential administration of Rutherford B. Hayes. In 1908 he won his M.D. degree from the University of Pennsylvania and shortly thereafter returned to his native Morris County. He devoted the rest of his life to the care of the people of that county, with an office in Madison for over 40 years. He was affiliated with the Morristown Memorial Hospital. Dr. Seward was coroner of Morris County for some years and was President of the Chester Board of Health for two decades. He was interested in obstetrics and was one of the pioneers in the development of safe technics for cesarean sections.

Announcements • • •

Physical Medicine-Rehabilitation Conference

The next session of the American Congress of Physical Medicine and Rehabilitation will be held September 9 to 14 at The Ambassador, Atlantic City, N. J. All sessions will be open to members of the medical profession.

In addition to the scientific sessions, annual instruction seminars will be held. These lectures will be open to physicians as well as to therapists.

Full information may be obtained from Dame Dorothea C. Augustin, American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Avenue, Chicago 2, Illinois.

Allergy Course in New York

Dr. Bret Ratner will conduct an intensive, one-day-a-week (all day) allergy course in New York every Wednesday from November 7, 1957 to May 29, 1957. Sessions run from 9 a.m. to 4 p.m. Tuition fee is $300. Enrollment is limited. Further details are obtained from the Dean, New York Medical College, 105th Street at Fifth Avenue, New York 29, N. Y.

Medical-Electronic Organization

In the March 1956 JOURNAL, we had an editorial on the better working-together of engineers and physicians. This has been widely reprinted. One of the results of that reprinting has been that our attention has been called to the existence of a "Professional Group on Medical Electronics." This organization presents a forum at which physicians and engineers are well represented. Readers interested in joining the New Jersey chapter can obtain further information from Mr. Carl Berkley, Allen B. Dumont Laboratories, 760 Bloomfield Avenue, Clifton, N. J.

Occupational Medicine Course

A full-time eight-week comprehensive course in occupational medicine will be given in New York from September 10 through November 2, 1956. The tuition fee is $350.

Among the subjects being offered to physicians are: organization and administration of an industrial medical department; preventive medicine in industry; occupational diseases; toxicology; industrial hygiene; biostatistics; communicable disease control and epidemiology. Opportunities will be provided for attendance at conferences during the course.

For further information and application address: Dean, N.Y.U. Post-Graduate Medical School, New York 16, N. Y.

Course in Gastroenterology

The American College of Gastroenterology announces its Annual Course at the Roosevelt in New York City, on October 18, 19 and 20. It will be under the direction of Dr. Owen H. Wangensteen, of Minnesota, who will serve as surgical co-ordinator and Dr. I. Snapper of Beth-El Hospital, Brooklyn, who will serve as medical co-ordinator. Drs. Wangensteen and Snapper will be assisted by a distinguished faculty.

The course will cover both medical and surgical aspects. It will include advances in diagnosis and treatment, a comprehensive discussion of diseases of the mouth, esophagus, stomach, pancreas, spleen, liver and gallbladder, colon and rectum, with special studies of radiology and gastroscopy.

For further information write to the American College of Gastroenterology, Department P. G., 33 West 60 Street, New York 23, N. Y.

Cancer Seminar 1956

Dr. Joseph I. Echikson, chairman of the Professional Information Committee of the American Cancer Society, New Jersey Division, has announced that the Fourth Annual Cancer Seminar for New Jersey doctors will be held on November 17 and 18, 1956 at Hotel President, Atlantic City.

Authors' Clinic • • •

How to Prepare Summaries and Conclusions

Your readers will be interested in the summary and in your conclusions. A summary is a resumé of the facts of the article. Conclusions are deductions or inferences. These two parts of your paper reflect your purpose in writing the article.

What is so important about a summary? From the reader's viewpoint, the summary tells him what the paper is all about. From the writer's viewpoint, the summary challenges the author to crystallize his observations. It reveals the inconsistencies in his findings.

The conclusions are what make the paper worth publishing. The author makes observations, and from them he draws inferences, gives advice, or offers help. These inferences and suggestions are "conclusions."

Many scientific journals have "abstract" sections. There are also indexing services which prepare abstracts of professional articles. If your paper ends with a compact and interesting set of conclusions, one of these journals or indexing services will pick it up. You will be pleased if other periodicals copy your conclusions, or if your summaries appear in indexing or abstracting services. Carefully written conclusions and summaries are tickets to such immortality.

SUMMARIES

An article that takes less than three typewritten (double spaced) pages probably needs no summary. A paper that runs to more than five or six such pages certainly needs one. This applies to the standard scientific article. Summaries and conclusions are seldom appended to essays, editorials, book reviews, meeting reports or formal orations.

Let us see how a summary is constructed. Suppose you have studied the effects of hydro-ergonine in peripheral vascular disease. You list the patients, describe the regime, and define "good" "fair" and "poor" results. You discuss the chemistry of hydro-ergonine. You describe and enumerate the side-effects. You compare this drug with other preparations, and you compare results in thrombo-angiitis with results in Raynaud's Disease. All this takes perhaps, six typed pages. Examine the summary and conclusions detailed below.

SUMMARY

1. Hydro-ergonine was administered sublingually to 100 patients suffering from peripheral vascular disease.
2. Of the 50 patients with Buerger's Disease, 9 showed good response, 15 showed fair response, and 26 showed poor response.
3. Of the 50 patients with Raynaud's Disease, 22 showed good results, 13 showed fair and 15 poor results.
4. No serious side effects were noted.

CONCLUSION

Hydro-ergonine helps about one-half of the patients with Buerger's Disease and about 85 per cent of those with Raynaud's Disease.

This is a common type of article: a report on the use of a new drug with note of side-effects. In preparing the summary, observe these factors. They refer to the summary above but apply to all articles of this type:

(a) Figures are rounded out. If the whole number is a round one (as "50 cases") you may cite the results in raw numbers — 22 good results, 13 fair, 15 poor results. If the whole number is less "round," cite the results in percentages, but only in whole percentages. If the percentages are easily equated to simple fractions, express them that way. Here's how:

Suppose you found that 76.3 per cent of the patients improved. The decimal fraction only clutters up your summary. Write it as 76 per cent; or better, as "about three-quarters of the patients improved." This conveys the idea faster and simpler than does the exact percentage. Nor is it less accurate. The extra 1.3 per cent (76.3 less 75 per cent) is meaningless.

(b) The summary mentions the route of administration but not dosage—unless dose can be expressed very simply. Usually dose has to be described in terms of so many milligrams per kilogram of body weight, or as a certain amount given at specified intervals. This slows down the reading of the summary, and is therefore omitted.

(c) Side effects are mentioned but not detailed.

Not all articles are of the "new drug trial" type. A paper might describe a new operative technic. In that case the summary would con-

dense the technic into several short sentences. Or the article might simply review some basic medical or physiologic facts. For example, here is the summary of a paper on the role of histamine in medical practice.*

1. Histamine has three important physiologic actions: (a) It contracts smooth muscle; (b) It dilates arterioles; and (c) It increases the permeability of capillaries.

2. Histamine may be administered subcutaneously by dissolving 1 milligram of the base in 10 cubic centimeters of isotonic salt solution.

3. Histamine is useful in Meniere's Disease and in the so-called "histamine headache."

4. Histamine is of little value in asthma, hay fever and other allergic states.

This abstract includes two "conclusions" (items 3 and 4) and two "summary" items. Notice how neatly this lends itself to reproduction by professional abstract writers.

CONCLUSIONS

Conclusions usually take the form indicated in 3 and 4 above—that is the conclusion is that this drug is helpful in certain conditions (naming them) and of no use in others (naming them). A typical conclusion, for example, would be: "Antibiotics should not be used in common colds unless specific indications are presented."

Here are other examples of conclusions:

"Venesection is not to be sneered at as an old-fashioned remedy. It is a treatment of choice in erythremia, and as a first aid measure in plethoric patients."

"A nevus should be removed surgically if (1) it bleeds; (2) It discharges any fluid; (3) Continues to get larger; or (4) Gets darker."

"Persons who work in the rayon or artificial silk industry are subject to carbon disulfide poisoning—a condition often overlooked by doctors. Symptoms include weakness, nausea, double vision, and numbness of the hands. This possibility should be in the forefront of the practitioner's mind when a worker in the textile industry shows these symptoms."

Review these three "conclusions." Notice that each is short, though each was derived from a lengthy paper. Notice how the author compressed his conclusions. Each writer lighted up some dramatic feature of his subject.

If you were looking for material to fill out the bottom of the page in some medical journal, you would be glad to use these bright little items. Properly presented conclusions are often used in just this way. Your paper stands a good chance of getting wide recognition if you can offer short, dramatic, usable conclusions.

NUMBERING OF SUMMARIES

Should summaries and conclusions be numbered? If the summary consists of several discrete items of approximately equal importance, it is a good idea to number each item. Look at the following example.

SUMMARY

A study of the effectiveness of chlorpromazine was made at the Essex County Hospital. Of a census of 3000 patients, 800 were found to meet presumptive criteria for the effectiveness of the drug.

1. About 20 per cent of the patients were materially helped.
2. In only 10 per cent was it necessary to discontinue the drug because of untoward effects.
3. The remaining 70 per cent were neither helped nor harmed by chlorpromazine.
4. Patients in agitated depressions were almost uniformly helped. Out of 92 patients in this group, 91 were substantially improved.
5. Patients in quiet depression gave mixed and unpredictable reactions.
6. Overactive, noisy patients were tranquilized, but their delusions were not affected.

In this example, notice that the two preliminary sentences are not numbered. This general paragraph is not coordinate with the six numbered sentences. Each numbered item represents a single finding. Numbering is an effective way of presenting the findings. This summary also illustrates the rounding out of figures and the dehydration of each sentence, so that no unnecessary words remain. This type of summary makes a conclusion superfluous, since the findings speak for themselves.

If the summary can be expressed in a short and simple paragraph, there is no reason for numbering the findings. For example:

SUMMARY

The teeth of 12 living apes were submitted to combinations of different foods and various bacteria. It was found that the most effective caries-producing combination was the action of the Lactobacillus Acidophilus on teeth which had previously been coated with carbohydrate. This consistently led to greater enamel decalcification than could be produced by any other combination.

*Adapted from a paper by Ralph I. Alford, M.D., published in THE JOURNAL of The Medical Society of New Jersey, 53:25, January 1956.

CONCLUSION

Caries in human teeth is probably due to the action of common mouth bacteria on carbohydrate food deposits.

In this case, there was no need to number the separate summary items. It could have been done this way:

1. The teeth of 12 apes were submitted to combinations of different foods and various bacteria.
2. The most effective caries-producing combination was the action of Lactobacillus Acidophilus on teeth which had been previously coated with carbohydrate.
3. This combination invariably led to enamel decalcification.
4. No other food-bacteria produced such consistent decalcification of enamel.

This numbering sounds stilted. The unbroken paragraph was better.

Sometimes it is practical to consolidate the summary and conclusions. This is true under these conditions:

(a) When the article is too short to justify two sections at the end.

(b) When the findings speak for themselves. Suppose, for example, you took a popular remedy — say Fowler's Solution — and found it was ineffective in the treatment of chorea. The simple recitation of that finding would speak for itself. You would not want to add as a "conclusion," the statement that Fowler's Solution was ineffective in chorea. This would be repetitious.

(c) When the purpose of the article is fulfilled by the presentation of facts without inferences. For example, you might make a study of the average income of specialists in medicine and dentistry. You might want to avoid any inferences at all. Your summary would consist of a simple listing of the facts —that this was the greatest income-producing specialty and that was the least.

THE EMPTY SUMMARY

Suppose you read a manuscript which, in considerable detail, discusses different ways of treating rupture of the sartorius parvus muscle. The author then lists the causes and describes how each cause operates. He summarizes the diagnostic findings. He discusses manipulative treatment versus open operation. He tells exactly how to apply a tourniquet during operation in order to get a bloodless field. He details exercises and methods of immobilization. His summary is:

1. The causes of rupture of the sartorius parvus muscle have been listed.
2. The differential diagnosis is discussed.
3. A case report is given.
4. Treatment technics are described and compared.

This summary is worthless. In fact, it is practically a fraud on the reader. It tells him nothing.

To protect yourself against an empty summary, try this test: could my summary and conclusions be lifted without editing and reprinted in some other journal? If that were done, would the reader of that abstract learn anything from it?

If your summary and conclusisns do not meet this requirement, rewrite them. Reshape them until they do.

One final point about conclusions: select the single most dramatic or most interesting sentence in your list of conclusions or, failing that, in your summary. Try making this the very first sentence of your article.

HENRY A. DAVIDSON, M.D.
Editor of The JOURNAL.

County Society Reports • • •

Atlantic

The regular meeting of the *Medical Society of Atlantic County* was held at the Children's Seashore House on April 13 at 9:00 p.m. The President, Dr. Peter H. Marvel, presided.

Harold J. Jeghers, M.D., Professor of Medicine, Georgetown School of Medicine, spoke on "Oral Lesions Indicative of Systemic Disease."

The President thanked Dr. Jeghers for an excellent presentation.

Dr. Marvel then opened the business meeting. The minutes of the previous meeting were approved as published in the *Bulletin*.

The following committee reports were made:

Legislative Committee: Dr. Allman and Dr. White reviewed the present status of state and national legislation.

Public Health Committee: Dr. Salasin reported on the poliomyelitis vaccine situation. He also announced that chest x-ray surveys would be held in September and he stressed the importance of the survey because of the high incidence of tuberculosis in Atlantic City. A committee will help in the survey drive.

New Business: Dr. Marvel appointed the following to the Nominating Committee: Dr. Stamps, Chairman; Drs. Holoman, Molitch, Rosenberg and Walter Stewart. Appointed to the Auditing Committee: Drs. Hersohn, Murray and Wilson. The Committees were asked to have their reports ready in time for the May Bulletin.

A resolution electing Arthur Edward Ewens, M.D., to emeritus membership was passed unanimously.

Dr. Diskan introduced the recipient of the third "Gold Medal Bulletin Award." The presentation was made to William Elmer Brown, Jr., Esq. Mr. Brown has been the honorary counselor to the Atlantic County Medical Society for many years, and has handled all the legal problems of the Society. He is a sincere and valued friend.

Mr. Brown accepted the medal and thanked the Society for honoring him.

The meeting was adjourned at 10:30 p.m.

LEONARD B. ERBER, M.D.
Reporter

Bergen

The Annual Meeting of the *Bergen County Medical Society* was held at Bergen Pines Hospital on May 8.

Dr. Anthony R. Colonna was elected a regular member on transfer from the Medical Society of New York. Elected to Courtesy membership were Drs. Jacques L. Kubrick and William I. Wolff. Dr. Joseph F. Duffy was reinstated to Regular membership.

An amendment to the Constitution and a series of amendments to the By-Laws adopted at the meeting created the new office of Assistant Treasurer. Another amendment clarified the authority of the Executive Committee to maintain an office and staff to handle the business of the Society.

The meeting was addressed by Mr. Basil Yurchenco, A.I.A., on "Designing the Medical Office." After a lively question and answer period following Mr. Yurcheco's presentation, the business meeting was reconvened.

The Legislative Committee presented a resolution approving the action of the Legislative Committee of The Medical Society of New Jersey in its position of active opposition to Senate Bill S-90.

Election of Officers: President — William T. Knight; First Vice-President—Leo J. Fitzpatrick; Second Vice-President—George Heller; Secretary and Reporter—Charles P. Campbell; Treasurer — Frederick L. Muller; Assistant Treasurer — John P. O'Connor. The above are the new officers for the year June 1, 1956 to May 31, 1957.

JOHN R. WILLIAMS, M.D.
Reporter

Camden

The Annual Meeting of the *Camden County Medical Society* convened May 1 in the meeting rooms of the Society with Dr. A. G. Pratt, President, presiding.

Drs. Matthew M. Mischinski and Edward M. Zehler were introduced after taking the oath of membership and signing the register.

Dr. Wright gave a report for his committee concerning suggested changes in meeting places in order to stimulate greater attendance. The committee felt that the fall meeting should be a dinner meeting followed by alternate meetings at the Executive Offices and one of the hospitals with no collation being served at the hospital meetings; and that the annual meeting should be combined with the outing.

Dr. Barnshaw, reporting for the Executive Committee, informed the membership of the report of the Survey Committee and likewise presented the matter of Senate Bill 57. The resolution expressing our disapproval of this bill requested by the Pharmaceutical Society was read.

Dr. Harold K. Eynon presented the problem now faced in this county concerning coroner's physicians who are not actual trained pathologists, yet the autopsies are done by pathologists. Dr. Eynon moved that the president appoint Drs. Read and Bowen to solicit the support of the pathologists at the two other hospitals to serve as county physicians thus dividing the work in three with appropriate division of fees. This was seconded and passed. Dr. Shipman moved that the same committee explore the possibility of establishing a Medical

Examiner's office in Camden County with a trained pathologist at its head. This was passed.

The following officers were elected: Dr. George P. Meyer, President; Dr. Frank Hughes, Secretary; Dr. Robert N. Bowen, Treasurer; Dr. Ralph Wright, President-Elect; Dr. Helen Schrack, Historian; Dr. Eugene H. Kain, Reporter. Dr. George P. Meyer assumed the chair and thanked the members for their confidence in electing him president.

Dr. Schrack gave a brief historian's report dealing generally with her experiences encountered in the securing of the biographies for the forthcoming anniversary publication. She informed the Society of the great amount of work and the cooperation of the Auxiliary in the procuring of the historical sketches of our membership.

EUGENE H. KAIN, M.D.
Reporter

Cape May

Recently elected officers for the *Cape May Medical Society* took office at the last meeting on May 22. The new officers are Edward B. Tyson, Ocean City, President; Carl J. Records, Cape May, Vice-President; Samuel J. Mazzotta, Wildwood, Secretary; and Harold F. Hughes, Cape May, Treasurer. The guest speakers at this session were Dr. John Frost, Associate Professor of Medicine; Dr. Harry Zinsser, Associate Professor of Cardiology, and Dr. Cunard, Associate Professor of Anesthesia, all at the University of Pennsylvania. Their topics of discussion were the heart and its management in hypo- and hyperthyroidism, pregnancy, anesthesia, and cardiac surgery. Charles Jonas, D.D.S., of Atlantic City then gave an illustrated lecture on orthodontia; Dr. Hilton Read, of Atlantic City, spoke on "Notions on Neurotics."

The Medical Bar Group had its annual dinner at the Flanders Hotel, Ocean City, on April 19. At this meeting an inscribed plate was presented by the society to Dr. George Dandois, *in absentia*, recently retired from active practice after many years of devoted duty in and about Wildwood.

SAMUEL J. MAZZOTTA, M.D.
Reporter

Gloucester

The annual meeting of the *Gloucester County Medical Society* was a highlight of the year when it met on May 17 at the Woodbury Country Club. Colleagues from nearby counties as well as guests and wives of the members enjoyed an address by Dr. Egbert R. Samuel of Mount Carmel, Pennsylvania, who was chosen General Practitioner of the Year by the American Medical Association. The group was also privileged in meeting his wife.

Before the address by Dr. Samuel, a short business meeting was held. The following were elected as officers for the 1956-1957 year: Chester L. Samuelson, President; James G. Kehler, Vice-President; Dorothy M. Rogers, Secretary; Francis M. Brower, Treasurer; Dorothy M. Rogers, Historian; Roger D. Lovelace, Reporter. At the conclusion of the meeting, an informal reception was held, and refreshments were enjoyed by all.

ROGER D. LOVELACE, M.D.
Reporter

Middlesex

The annual social outing of the *Middlesex County Medical Society* was held at The Forsgate Country Club, Jamesburg, on Wednesday, May 23.

No business matters were transacted at this meeting. At 7:00 p.m. a roast beef dinner was served to 95 attending members. Golf and various other games took up the afternoon session.

From 8:00 p.m. to midnight dancing was enjoyed.

ALFRED J. BARBANO, M.D.
Reporter

Monmouth

Fitkin Memorial Hospital, Neptune, was host to the *Monmouth County Medical Society* at its regular monthly meeting on May 23. Dr. William F. Jamison, President, presided.

The following amendment to the Constitution was adopted:

"Article V—Meetings

Section 1. The regular meetings of this Society shall be held monthly, except July and August.

Section 2. Attendance at meetings limited to: (a) Members of this Society, or of the American Medical Association or of its constituent State or County Societies and to physicians eligible to membership in any of these societies. (b) Interns and Residents of any Approved Hospital. (c) Members of the Legal, Nursing, Pharmaceutical, and Dental professions, by invitation. (d) Invited guests, either of the Society or of an individual member."

An open discussion was held to acquaint the Executive Committee with the views of the membership at large on the Salk Polio immunization program.

Dr. Henry A. Davidson, author of *Forensic Psychiatry* and Editor of The Journal of The Medical Society of New Jersey, was guest speaker. His subject was "The Doctor as a Witness." The talk was most informative and thoroughly enjoyed by all. The Honorable John C. Giordano, Monmouth County Court Judge, and Dr. Daniel Featherston offered interesting commentaries on the presentation.

DONALD W. BOWNE, M.D.
Reporter

Passaic

The regular monthly meeting of the *Passaic County Medical Society* was held on April 17 at 9:00 p.m. at the Medical Society Building. Dr. Joseph R. Jehl the President presided.

The following physicians were elected to membership: Associate membership, Dr. Salvatore Sapienza of Paterson; courtesy membership, Dr. Saul M. Grandinetti of Clifton.

Dr. Frank R. Schell, Chairman of the Committee on Radiology, presented a resolution. After considerable discussion and a slight change in the wording contained in the original resolution, a resolution was adopted by the members on the Blue Cross-Blue Shield Plan.

Dr. Shulman, Chairman of Public Relations and Public Health Committee, read a reply received from the American Medical Association, to a request made by the Society for comment on a full page advertisement carried in a local newspaper. This advertisement was entitled "Chiropractic Answer to Cancer." Dr. Shulman said that he will follow this further with the newspaper, as a public health matter.

Dr. Jehl called attention to the letter sent by the Woman's Auxiliary to the members of the Society, in connection with the Society for the Relief of the Widows and Orphans of Medical Men of New Jersey, urging the doctors to become members for the protection of their families.

The President then turned the meeting over to Dr. Christopher T. Reilly who introduced the speaker, J. Robert Willson, M.D., Professor of Obstetrics, Temple University, Philadelphia. Dr. Willson's topic was "Recognition and Treatment of Pre-Eclampsia," after which a question period followed.

DAVID B. LEVINE, M.D.
Reporter

New Jersey Allergy Society

At the annual Atlantic City meeting of the *New Jersey Allergy Society*, the following officers were elected for the year of 1956-57:

President: Dr. E. J. Luippold, Boonton.
Vice-President: Dr. Harry Hershey, Jersey City.
Secretary: Dr. Frank H. Feldman, Newark.
Treasurer: Dr. Francis A. Pflum, Asbury Park.
To Executive Board: Dr. Solomon Aronoff, Jersey City.

FRANK H. FELDMAN, M.D.
Secretary

New Jersey Dermatologic Society

At the recent annual meeting of our Society, the following officers for 1956-57 were elected:

President: Bart M. James, M.D., East Orange.
Vice-President: Seymour L. Hanfling, M.D., East Orange.
Secretary: John R. Tobey, M.D., Newark.
Treasurer: Samuel Fisher, M.D., Paterson.

JOHN R. TOBEY, M.D.
Secretary

Radiologic Society of New Jersey

At the last annual meeting of the *Radiologic Society of New Jersey*, May 16, the following officers were elected for the year 1956-1957:

President—Dr. Carye-Belle Henle, Newark.
Vice-President—Dr. Louis J. Levinson, Newark.
Secretary—Dr. George G. Green, Asbury Park.
Treasurer—Dr. William L. Palazzo, Teaneck.

GEORGE G. GREEN, M.D.
Secretary

Widows and Orphans Society

The 74th Annual Meeting of this Society was held May 7, at the home of the president in Newark.

The officers and trustees whose terms expired were all re-elected. They are: President, Earl LeRoy Wood, Newark; Vice-President, Berthold T. D. Schwarz, Montclair; Secretary, Herbert M. Ill, Glen Ridge; Treasurer, Harold A. Tarbell, Newark; Custodian, Herbert A. Schulte, Newark. Directors: William D. Minningham, Newark; Elbert Sherman, Maplewood; A. Julius Gordon, Newark.

Total membership is 646. During the previous year 38 new members were enrolled; 19 died; and 5 resigned or were dropped for non-payment of assessments. During the year, fifteen assessments were paid by the members. The amounts paid to each beneficiary averaged about $575, an increase over previous years. This was fully paid in one sum and checks were sent promptly after the notification of death was received by the Treasurer. Delay occurred only if the record of death and the name and address of the beneficiary were not at hand. A total of $9733 was paid in benefits from the $10,484 received from the member assessments.

The Permanent Fund of the Society amounts to nearly $85,000 and from its income $2100 was used to continue assistance to several needy widows of former members.

It was suggested that members who have not already done so be requested to consider payment of assessments in advance by sending $10 or more at a time. This would reduce bookkeeping, check and postage costs, and would also contribute to the convenience of the members. This economy to the Society is also in the interest of its members who benefit thereby.

HERBERT M. ILL, M.D.
Secretary

Book Reviews • • •

Textbook of Medical Physiology. Arthur C. Guyton, M.D. Philadelphia 1956. Saunders Pp. 1030. ($13.50)

Physiology is the basis of all disease *process*. Yet, until recently, it was far more neglected than pathology, which as generally taught, is simply disease *structure*. Many of the faults of modern medicine are rooted in the static picture of disease structure that comes from teaching medicine through the house of the dead—the autopsy table. Disease as "process" is understandable only if normal physiology is understood.

But physiology is often made to seem so remote from practice, that the physician is frightened by it. Can the average practitioner really manipulate the formula for determining effective filtration pressure in the glomeruli? Does he use the coefficient of oxygen utilization in cells of the sartorius muscle? When the standard physiology text plunges him into this, the practitioner calls a halt to further studies in physiology.

Here Guyton comes to his rescue. This unpretentious work relates physiologic process to medical practice. If it is undistinguished in writing style, it is, at least, lucid. If, at points, it appears dogmatic, it is at least concise. The diagrams are simple, uncluttered and easy to read. It is a useful manual, focussed on the needs of the medical student. And this is an area where all practitioners remain students.

VICTOR HUBERMAN, M.D.

Hypnotic Suggestion. By S. J. Van Pelt, M.B. New York 1956. Philosophical Library, Pp. 87 plus references and index. ($2.75)

For $2.75 you can get an 87 page booklet which takes the position that hypnosis is a major etiologic component of psychosomatic conditions. The author also believes that these conditions can be cured by light hypnosis. He is vague about the methods of inducing the light hypnosis, giving this a once-over lightly in a scant 5-page chapter. He denies that hypnosis is related to sleep and believes instead that it is due to a "super-concentration" of the mind. ("The patient is *en rapport* with himself"). The author's plan is to give a treatment once a week and allow the patient "to practice for himself" between sessions. "The actual number of sessions required" says the writer in a triumph of optimism "varies from 4 to 6, or in some very difficult cases, even twelve."

HERBERT BOEHM, M.D.

A Course in Practical Therapeutics. By Martin E. Rehfuss, M.D. and Alison H. Price, M.D. Baltimore 1956. Williams and Wilkins. Pp. 972. Ed. 3. ($15.00)

Want to know how to prepare a flaxseed poultice or a turpentine stupe? Look on page 53. Do you know that a prescription includes a superscription, an inscription, a subscription and . . . ? That raspberry syrup is excellent for concealing unpleasant taste in prescriptions? That antibiotics maybe are not here to stay, that a patient with "unstable nerves" (sic!) may be driven into panic, and that nux vomica is a "stomachic"? This heavy volume has an enormous amount of practical information —what to keep in a doctor's bag, how to differentiate one type of cough from another, how to inject a joint for bursitis, how to tap for dropsy, and how to develop the proper diet for kidney disease.

A nostalgic air of the 1920s permeates this giant-size volume. It is written in leisurely pace, chock full of stereotypes. (Example: if the patient has several diseases, give primary consideration to the one that threatens life. The physician who treats ulcer must watch out for hemorrhage. The successful doctor is one who has courage, confidence and skill . . . and so on. And on.) The material on diet and prescription writing is decidely of the Warren G. Harding era. The tome's usefulness is enhanced by many diagrams showing, for instance, differtial diagnosis of liver disease, how to give an intravenous, how to insert a postnasal pack and the differential diagnosis of mumps. The authors tell how to prevent bed-sores and how to isolate a patient with contagious diseases. The therapeutic advice, even if somewhat overloaded with trade-named proprietaries, is very homely and practical. There is a one-hundred page section on how to relieve symptoms, ranging alphabetically from acidosis, through priapism, to vertigo. Then comes a section on specific disorders—catarrhal stomatitis, Plummer-Vinson syndrome, diverticulitis, gallstones, and so on, through the body systems. And if you ever get a case of kwashiorkor, you'll learn how to treat it on page 186. (Skim milk, banana, sugar and water). According to the authors, kwashiorkor is "the most severe and common nutritional disorder of man."

The book includes a number of excellent, compact chapters (written by specialists) on the specialties in general practice. This section covers such fields as pediatrics, radio-isotopes, psychotherapy, gynecology, dermatology, steroid therapy, "nasal therapeutics," and electrolytes.

HARVEY BLUESTONE, M.D.

TUBERCULOSIS *Abstracts*

Supplied by New Jersey Trudeau Society

ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

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THE NON-HOSPITALIZED TUBERCULOSIS PATIENT

By Edward T. Blomquist, M.D., American Journal of Public Health, February, 1956.

Changing emphases and concepts in the tuberculosis problem in the United States have given rise to assumptions concerning the characteristics and status of tuberculosis patients who are not hospitalized, which are not supported by valid evidence. The Public Health Service has therefore undertaken to provide statistical data that will reliably describe the current status of known non-hospitalized tuberculosis patients in sample areas of the continental United States, so that health departments and other agencies may have specific information on which to plan.

The specific purpose of this undertaking is to study the characteristics of non-hospitalized tuberculosis patients who are in need of intensive public health supervision and to provide information on the types of care and services given them.

By means of sampling techniques 37 areas of the United States were selected. Together, these areas consititute an unbiased sample census of the number and status of known non-hospitalized cases for the United States as a whole. The 37 areas in the study had a total population of almost seven million and constitute portions of 24 states. No area was representative of any state; rather, the 37 areas combined are representative of the entire nation.

The latest information on the status of all tuberculosis patients in need of intensive public health supervision in 37 areas showed that slightly more than half (55 per cent) were hospitalized cases and 45 per cent non-hospitalized cases.

The original selection of cases was made from the tuberculosis case register or the master index of reported cases. Cases for whom the health department had no information during the last five years were not included. Cases with disease activity questionable, undetermined, or not stated were included and particular effort was made to obtain their clinical status. The most recent information available regarding clinical status, medical supervision, and public health nursing and social services provided during the six-month period preceding the study date was obtained. This was done by reviewing clinic, public health nursing and hospital records, by conferences with private physicians and other personnel in hospital outpatient departments, Veterans Administration and social service agencies. Home visits were made when necessary.

In each area the cases included were those known to be active at home as of the study date. Total cases eventually included not only cases known to be active, but all current positive sputum cases regardless of clinical status or treatment recommended. Cases known to be taking drugs or to have drugs recommended were included regardless of status because such cases require substantial resources for their care and supervision.

ACTIVITY CLASSIFICATION OF NON-HOSPITALIZED TUBERCULOSIS CASES

	Number	Per cent
Total	3,159	100.0
Total active and presumably active	2,272	71.9
Active and probably active, seen in past year	1,896	60.0
Presumably active, current activity status indefinite*	376	11.9
Arrested or inactive with drug therapy prescribed	887	28.1

*These cases did not have any activity report within the 12 months preceding the study date, even though the latest diagnosis was active or probably active except for 20 cases classified as arrested with positive bacteriology.

Plainly, the situation revealed in this table has many implications for health departments and other agencies. The community has as great a responsibility for those cases outside hospitals as for those that are hospitalized. Because of the difficulties involved in supervising patients who are not in institutions, medical, nursing, and social services will be particularly challenged. Health departments will be concerned about the chances of spread of the disease because of the presence of active cases in their communities.

One-fourth of the cases had been known to health departments less than one year, three-fourths had been known for less than five years and 90 per cent had been known less than ten years. Thus an overwhelming number of cases at home are in need of that kind of public health supervision required soon after diagnosis.

About half of these non-hospitalized cases that need intensive public health supervision are 45 years of age and older. The age distribution is similar to that of newly reported cases. Obviously our tuberculosis control problem is proportionately greater in the older age groups. The study cases showed that the ratio of males of all ages to females of all ages was 60 to 40.

In ages over 35 there are more than twice as many males as females. Only 3 per cent of the cases for whom this information was available were in the minimal stage of the disease, 41 per cent were moderately advanced and 46 per cent were far advanced. The bacteriological status of the active and presumably active tuberculosis cases was unknown or undetermined within the preceding six months in 48.2 per cent of the cases. Twenty-four per cent were bacteriologically positive and 27.8 per cent negative. These data point out clearly that the cases at home include: (a) a large proportion which are positive; and (b) an even larger proportion which do not have a sufficient bacteriological determination to permit the public health agency to give realistic advice regarding prevention of the spread of disease.

Availability of facilities for medical supervision is directly related to density of population. All of the eight large cities in this study provide clinic, public health nursing and social services, while almost one-half of the study population in rural areas have no clinic services available. Ten per cent have no public health nursing service, and 80 per cent have no social services other than financial assistance, provided by departments of public welfare. Organized home-care programs exist in only two of the cities included in this study, and they supervised only 1 per cent of the total load.

It has been assumed that patients under supervision at home have drugs prescribed. The study shows that only a third have both bed rest *and* drug therapy recommended. Of the 922 patients with no recommendations known for either drugs or rest, more than half are not under medical supervision, insofar as could be determined.

It is significant that for 25 per cent of the active cases no medical recommendations for or against hospitalization were available. Only 5.5 per cent of the cases were recorded as awaiting hospitalization, almost 30 per cent were not hospitalized because of medical preferences. Certain areas of incompleteness of our data probably reflect an inadequacy of communication among health department physicians, tuberculosis hospitals, and other agencies.

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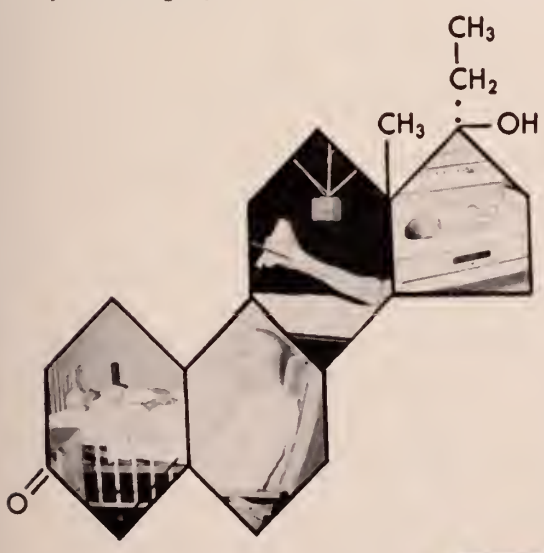
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*Modell, W.: The Relief of Symptoms, Philodelphio, W. B. Saunders Compony, 1955, pp. 265-266.

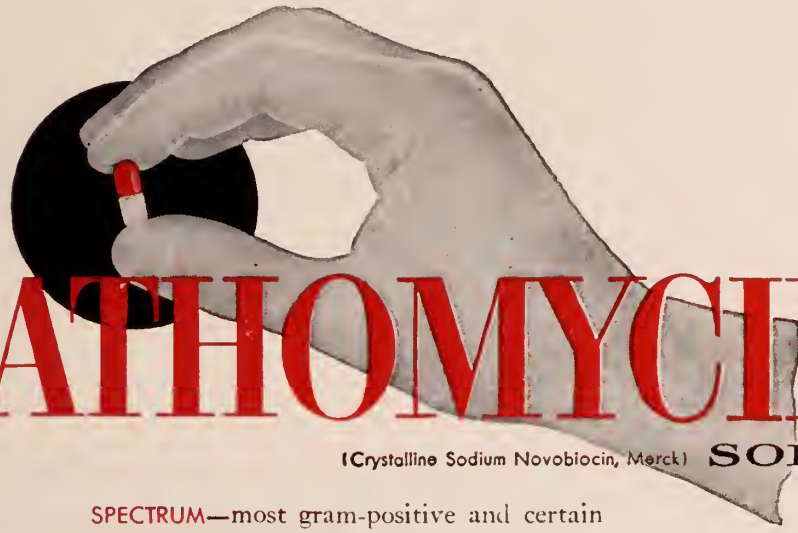
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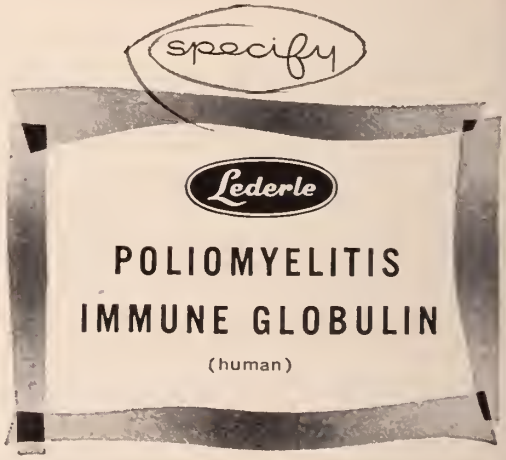
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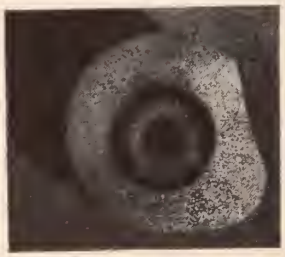
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*Silbert, N. E., Ciba Clinical Symposia; 6: 86; May 1954
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Rosen, F. L., J. Med. Soc. N. J.; 51: 110; March 1954
Mueller, H. L., & Hill, L. W.: N. E. J. of Med; 249: 726, 1953

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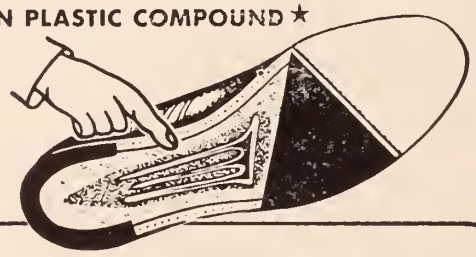
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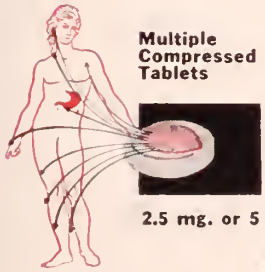
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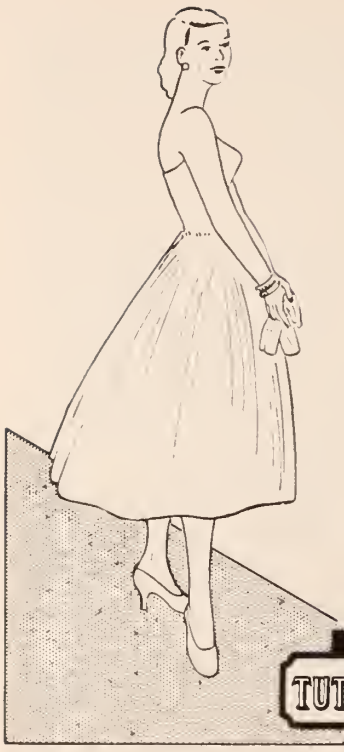
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1. Johnston, T. G., and Cazort, A. G.: J. Allergy 27:90, 1956. 2. Schwartz, E.: New York J. Med. 56:570, 1956. 3. Schiller, I. W., et al.: J. Allergy 27:96, 1956.

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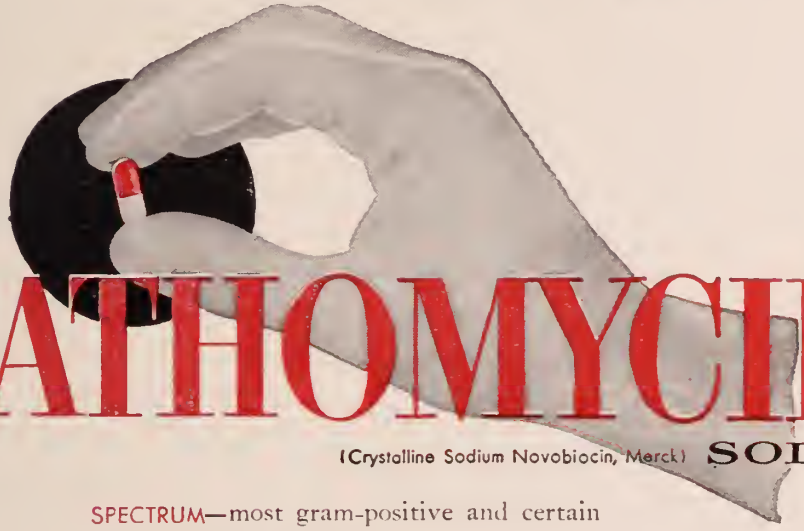
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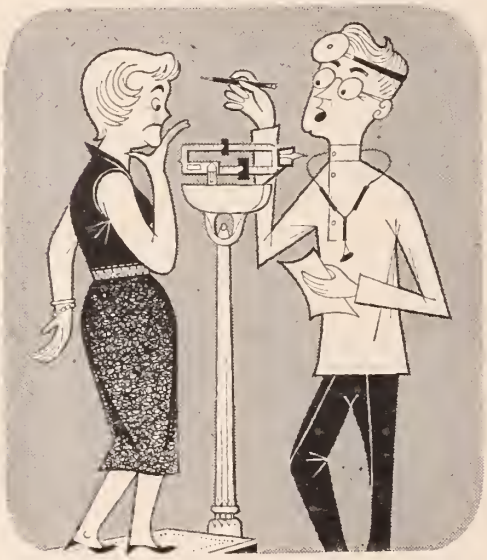
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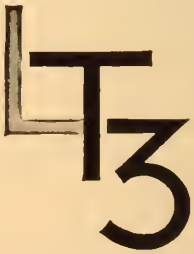
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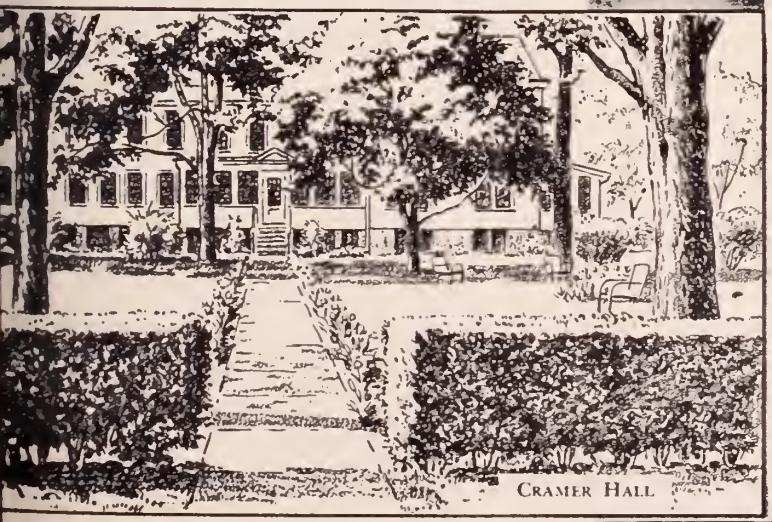
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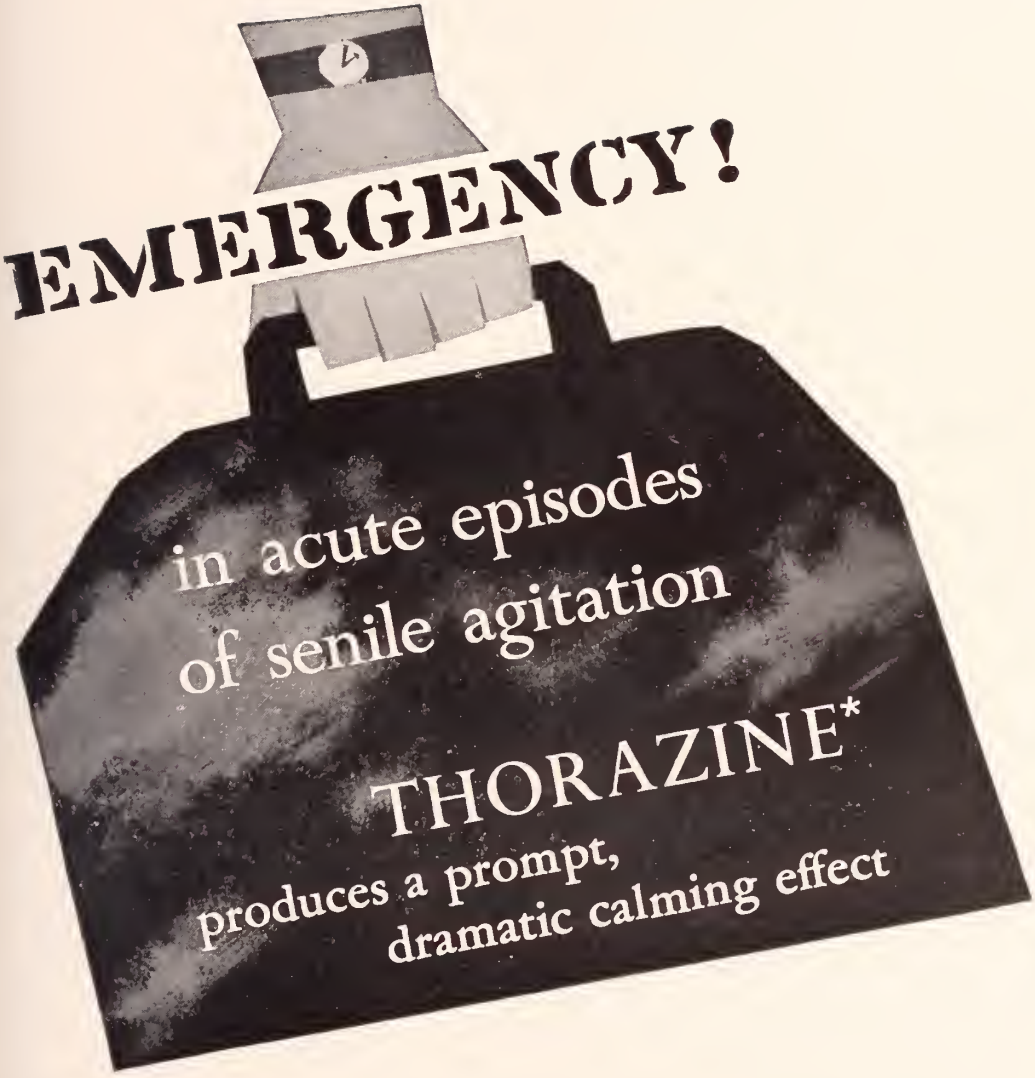


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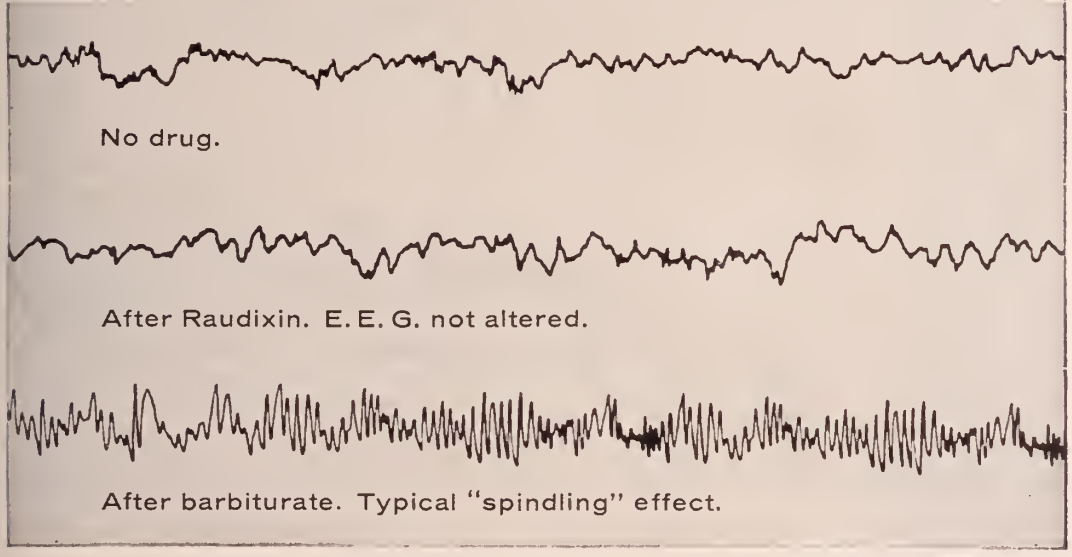


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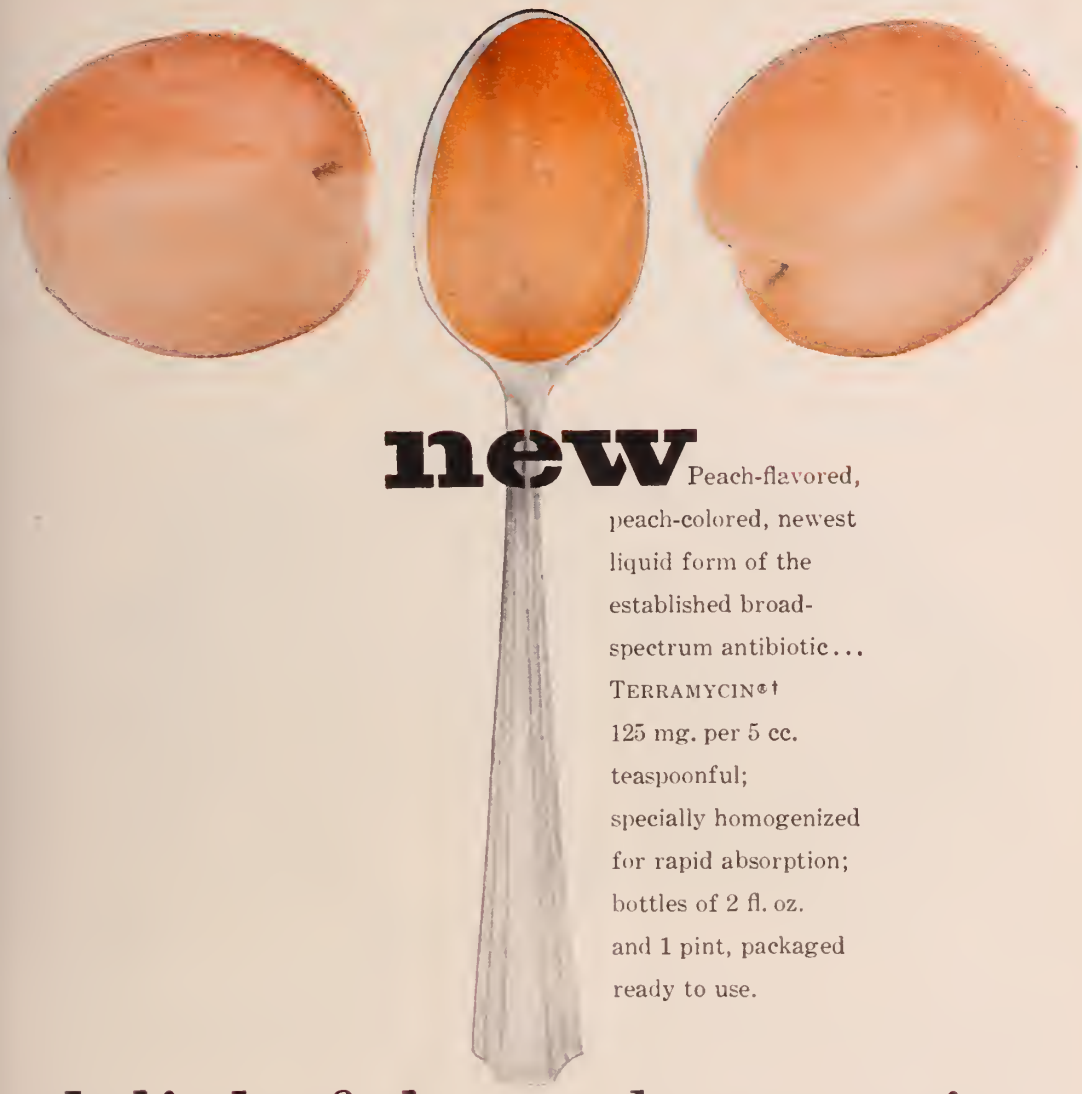
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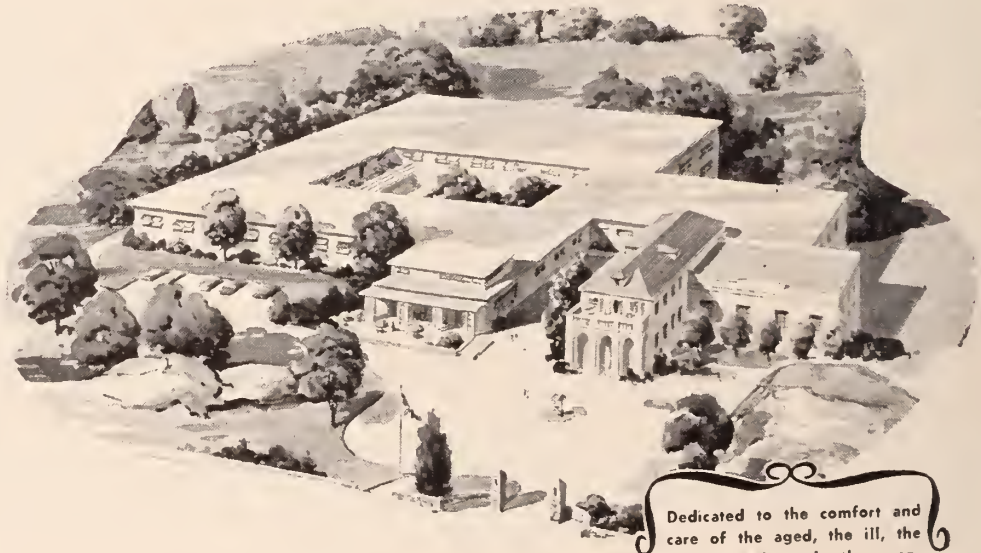
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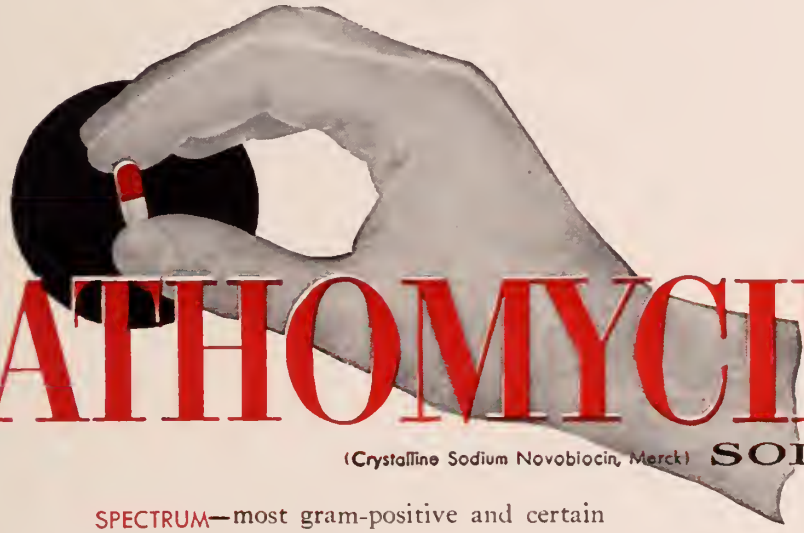
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SPECTRUM—most gram-positive and certain gram-negative pathogens.

ACTION—bactericidal in optimum concentration even to resistant strains.

TOXICITY—generally well tolerated. This is more fully discussed in the package insert.

ABSORPTION—oral administration produces high and easily-maintained blood levels.

INDICATIONS—cellulitis, pyogenic dermatoses, septicemia, bacteremia, pneumonia and enteritis due to *Staphylococcus* and infections involving certain strains of *Proteus vulgaris*, including strains resistant to all other antibiotics.

DOSAGE—four capsules (one gram) initially and then two capsules (500 mg.) twice daily.

SUPPLIED—250 mg. capsules of 'CATHOMYCIN', bottles of 16.

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>
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2 sec. CONTACTS
4 sec. COMPLEXES
6 sec. DISSOLVES
8 sec. DENATURES
10 sec. SWELLS
15 sec. EXPLODES
16 sec. SCATTERS

References: 1. Davis, C. H.: J.A.M.A. 157:126 (Jan. 8) 1955. 2. Davis, C. H.: West. J. Surg. 63:53 (Feb.) 1955. 3. Davis, C. H., and Grand, C. G.: Am. J. Obst. & Gynec. 68:559 (Aug.) 1954. 4. Davis, C. H. (Ed.): Gynecology and Obstetrics (revision), Hagerstown, Md., W. F. Prior, 1955, vol. 3, chap. 7, pp. 23-33. 5. Draper, J. W.: Internat. Rec. Med. 165:563 (Sept.) 1955.

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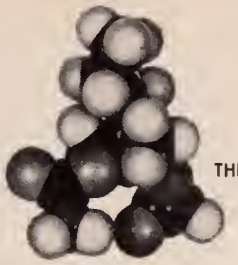
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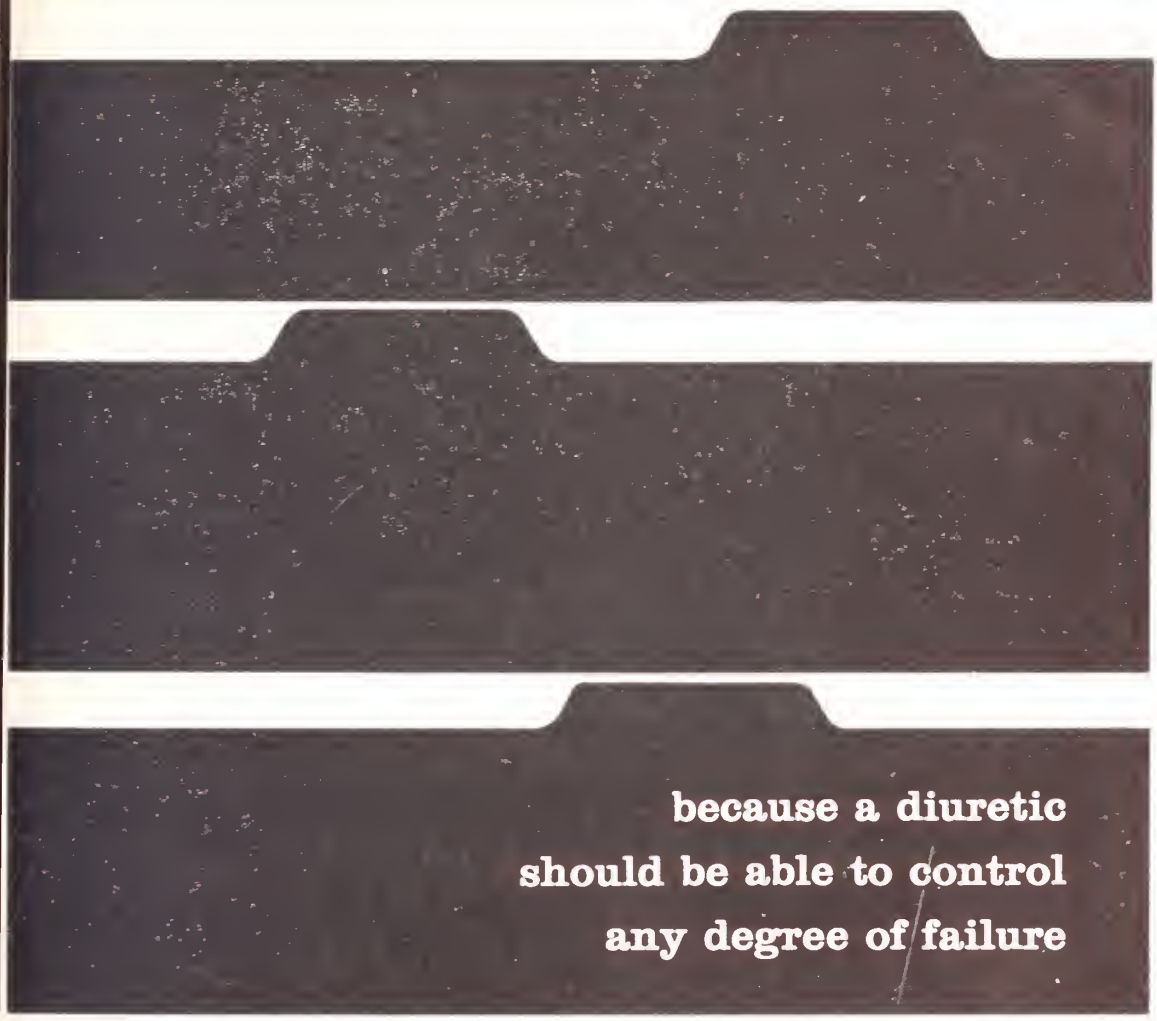
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1. Braceland, F.J.: Texas State J. Med. 51:287 (June) 1955.
2. Lemere, F.: Northwest Med. 54:1098 (Oct.) 1955.



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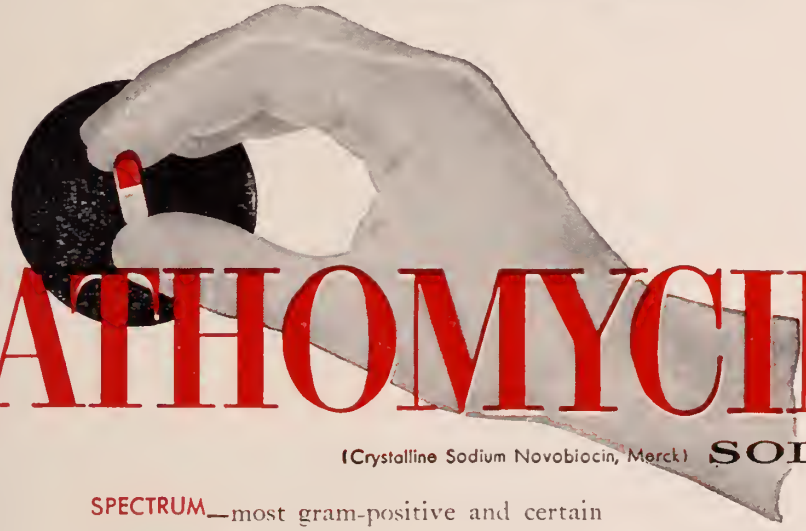
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ACTION—bactericidal in optimum concentration even to resistant strains.

TOXICITY—generally well tolerated. This is more fully discussed in the package insert.

ABSORPTION—oral administration produces high and easily-maintained blood levels.

INDICATIONS—cellulitis, pyogenic dermatoses, septicemia, bacteremia, pneumonia and enteritis due to *Staphylococcus* and infections involving certain strains of *Proteus vulgaris*, including strains resistant to all other antibiotics.

DOSAGE—four capsules (one gram) initially and then two capsules (500 mg.) twice daily.

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TOLERANCE—'CATHOMYCIN' is generally well tolerated by most patients. [5,6,8,9,10,11]

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INDICATIONS: Clinically 'CATHOMYCIN' has proved effective for cellulitis, carbuncles, skin abscesses, wounds, felons, paronychiae, varicose ulcer, pyogenic dermatoses, septicemia, bacteremia, pneumonia and enteritis due to *Staphylococcus* and infections caused by susceptible strains of *Proteus vulgaris*.[6,7,8,9,10,11,12,13,14] Also, it is of particular value as an adjunct in surgery since staphylococcic infections seem prone to complicate postoperative courses.

DOSAGE: Four capsules (one gram) initially and then two capsules (500 mg.) twice daily.

SUPPLIED: 'CATHOMYCIN' Sodium (Crystalline Sodium Novobiocin, Merck) in capsules of 250 mg., bottles of 16.

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DOSAGE: Generally, 0.2 to 0.4 mg. I.V. or I.M. immediately following delivery of placenta. Thereafter, 0.2 to 0.4 mg. three or four times daily for two weeks.

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OF
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Editorials • • •

The Clinician as a Researcher

The word "research" conjures images of a chrome-plated laboratory filled with electronic gadgets attended by white-coated physiologists, technicians and engineers. And, in truth *basic* medical research does require the laboratory. Basic medical research seeks to unlock the secrets of physiology, body chemistry, tissue pathology and the like. It deals, in a sense, with pre-human processes—or at least with processes common to all living matter. Its familiars are the kymograph and the guinea pig. The day has passed when a lone researcher in attic or cellar, using home-made equipment, spark-plugged only by his own genius, when such a one in such a setting could pry Nature loose from some of her secrets. Basic research today requires a team and a work room.

Clinical research is different. It is, in a way, a by-product of diagnostic or treatment methods. You collect many cases of this and notice that most of them have a certain finding in common. You give this drug or that to so many patients and note these good results and these side effects. But the basic building block of clinical research is the individual case report. When the groundwork for modern medicine was being laid in the nineteenth century, the medical literature was filled with individual case reports—a strange case of that, an unusual case of this. In our present mass-production culture, the individual case report looks wistful. Yet it remains, the indispensable architectural unit of medical progress. Follow back the chain from any major medical observation today and eventually you come to the tap root, the "first reported case."

The laboratory is not the only area of research. The library is one and the sick-room

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is the third. The "library" includes not only the indexed medical journals, but also the hospital record library. With its careful cross-indexing of diseases and complications, it furnishes a gold mine of data for the one who had patience enough to dig in the mine. Stored in the file cabinets and index records of 7000 hospitals in this country are answers to many medical mysteries, awaiting only the curious doctor willing to shape a key to fit the lock. Buried in these archives are records of millions of patients (some 200 million discharges in the past decade alone!). What a wealth of material lies here for the one who will take the trouble to till the field! And in the medical journals that pour from the presses are recorded a myriad of facts and fantasies for the researcher. Here you will find if any one else has had a case like yours and what they thought of it.

And then there is the therapeutic trial itself. You can try the proposed procedure or medication and see what it does for the patient. You can note results, and have a mathematically sophisticated friend apply the statistical formulae needed to make sure the results weren't due to chance. (Don't omit this step, or your conclusions will lack validity). You can fix all factors except the one of treatment to make sure that differences were due only to the treatment program. You can use a double-blind technic to eliminate the emotional effect. And then, without any electronic equipment or chromium cabinets, you are doing research.

Some of the most eminent pioneers in medical research were clinicians. There is, of course, the imperative of time. But busy men somehow manage to find time for important things.

The Shrinking Area of Ignorance

We are always learning new scientific truths. Since, presumably, there is only a finite amount of truth in science, the more we learn, the smaller the remaining dark area of ignorance. This suggests the hypothesis that, eventually, *terra incognita* will shrink to zero and there will be nothing more to learn.

No one seriously expects this to happen, and it is interesting to wonder why it won't. Take our own discipline for instance: we have enough trouble mastering that so we will not speculate about ultimate truths in mathematics, botany and atomic energy. Every disease has a cause, but you can run down the index of any medical book and see lots of diseases of unknown cause. You would think that part of the progress of science would be the transfer of diseases from the "unknown cause" to the "known cause" column. And it *is* true, that for a few diseases that has happened. But even here, the change has been more in words than in fundamental concepts. For example, a century ago, paralysis agitans was a disease of unknown cause. Today we know it is usually due either to encephalitis or to arteriosclerosis.* But are we much forwarder? We don't honestly know what causes encephalitis *or* arteriosclerosis. Parkinsonism has moved into the other column, but it hasn't reduced our area of ignorance very much. (It's like the observation of yesteryear that we know why morphine puts people to sleep: it's because it has a dormative principle in it! So with "virus" causes).

When it comes to knowing the effective treatment, we have made vast progress on one line, but this has simply shifted much of the traffic to the other line. Thus, we now save from death many people who suffer from septicemia, pernicious anemia, diabetes, pneumonia and so on. Actually, what we do is postpone death not conquer it. So we now have a skyrocketing incidence from other chronic dis-

*Except for a group of idiopathic cases, listed in the new *Nomenclature* as "of uncertain cause."

eases, particularly malignancies and cardiovascular disorders. And here we still have enormous areas of ignorance.

It is as if there were a joker in the background who manufactured new areas of darkness every time we got some light into one of the old corners. It is, one suspects, the destiny of man ever to be confronted with impenetrable mysteries and unconquerable frontiers. And, fortunately, it is destiny, too, to keep on trying to unwrap the enigma and cross the frontier. The mathematical formula apparently does not apply. As we open new areas to knowledge, we do not seem to reduce the total acreage of our area of ignorance. Somehow there is always another mountain to climb.

The Compliant Patient

He is the star player in every doctor's dream: the compliant patient. Here is the man who automatically trusts the doctor; the one who accepts as a pronouncement from Olympus, every truth, half-truth, or evasion that the doctor finds it necessary to utter. Here is the patient who will go to bed at 11 p.m. when told to do so, and even manifest that greatest triumph of self-restraint: limit himself to one salted peanut if the doctor so decrees.

If your father—or better your grandfather—was a doctor, you will have heard of this paragon. It was in his generation that the phrase "your're the doctor" meant "what you say goes." He not only cooperated 100 per cent with medical instructions, he didn't even ask if the lesion was benign or malignant. He didn't want to know his blood pressure and he would have thought it irreverent to ask what was meant by the scrawl on a prescription blank. (As soon, indeed, as demand an annotation to the Ten Commandments).

The modern fashion has it that the fact-demanding patient will get better quicker. The theory is that, being informed ("educated"?) about his illness, he will cooperate more intelligently. One wonders though whether the half-truths perceptible to his nonmedical mind will not cause worry. If so, will not worry, by way of ulcers, hypertension or other morbid change, aggravate the illness? Again, will not the half-educated patient challenge the therapy before he cooperates with it? It would seem—in terms of material results—that there is something to be said for the compliant patient.

Any ideas as to where to find him—or how to make him?

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Management of Complications of Myocardial Infarction*

While much has been written about the treatment of acute myocardial infarction, the literature is meager about the management of its complications. This practical article by Dr. Klein fills that gap.

EVER since President Eisenhower's heart attack, there has been an upsurge of public curiosity about the intriguing disease of coronary thrombosis. Tested for its potential of interest in the laboratory of time, this pathologic process still registers powerfully in the mind and imagination of the doctor.

PATHOGENESIS

THE three chief coronary arteries are the right circumflex, the anterior descending branch and the left circumflex. Most cases seen by the physician are thromboses affecting branches of these vessels. The area of the infarct depends upon the size of the artery occluded and upon the all important degree of available collateral circulation. Coronary thrombosis can occur slowly, affecting the lumen of the vessel over a period of days or weeks; or it may be an abrupt occlusion. There must be damage to the intima of the artery in order to have thrombosis. The usual cause of this damage is atherosclerosis. Less frequent causes of the atheromatous changes are syphilis, rheumatic fever, systemic infections or thromboangiitis obliterans.

SYMPTOMATOLOGY

THE clinical manifestations of myocardial infarction due to acute coronary thrombosis vary from occult asymptomatic episodes to severe attacks with prolonged pain, shock and pulmonary edema. The commonest symptom of the acute attack is pain. This is a very individual complaint. It has been variously described as agonizing, sharp, crushing, and vise-like. It does not depend on the size or location of the infarct but rather on the patient's sensitivity to pain. Although there usually is a substernal component to the pain, it may radiate upward or downward, to the left or to the right chest, to the left or right shoulder, to either arm, to the back or to all of these areas. There may be nausea and vomiting. Repeated doses of opiates may be required to give relief. At this time, the patient becomes cyanotic or ashen gray. He usually is sweating profusely, is dyspneic and extremely apprehensive.

Within a few hours, the blood pressure be

*Read before the Section on Cardiovascular Diseases at the Annual Meeting, The Medical Society of New Jersey, May 15, 1956.

gins to fall. The temperature rises as does the white cell count. The heart sounds may be rapid and faint. Cardiac irregularities may occur. The electrocardiogram may be normal in this early stage or it may show only a flattening of the T wave or slight ST segment elevation before any anterior or posterior patterns become apparent. In 24 hours, the temperature may reach 101 and the white cell count approximate 15,000. A pericardial friction rub is heard in about 10 per cent of the cases and usually does not appear until the second or third day. This evidence of pericarditis generally is transient, though it may last a week or longer. The fever, leucocytosis and sedimentation rate reach their height within a week, then gradually decline to normal well within a month. Most acute attacks can be distinguished by the three principal features of pain, fall in blood pressure (even to shock levels) and dyspnea. In uncomplicated cases, the pain subsides in 24 hours and usually does not recur. After the appearance of the typical electrocardiographic pattern, the tracing goes through progressive changes which may take weeks or several months before stabilization occurs. At times, the electrocardiogram may revert to the normal or pre-infarction pattern. The symptoms of myocardial infarction may be very mild lasting only hours or less; or they may persist for days in spite of all our therapeutic weapons.

TREATMENT

THE rationale of the therapy of acute myocardial infarction is complete rest, mental and physical. Much difference of opinion is expressed about the duration of complete bed rest. The pendulum still swings from the time honored minimum of four weeks to the extreme of immediate chair rest. Whichever principle you follow, the vital factor is to individualize or grade your case and then act accordingly. Remember that more effort can be expended in struggling with a bedpan than in using a bedside commode. The relief from pain should be prompt and complete. Morphine, 15 to 30 milligrams (grains ¼ to grains ½) subcutaneously gives the most effective comfort if tolerated. However, dihydromorphinone (commercially available under the Bilhuber-Knoll tradename of Dilaudid®) and meperidine (tradenamed by Winthrop-Stearns as Demerol®) may be substituted.

Oxygen therapy is indicated in all moderate or severe cases, particularly when pain is resistant to other measures, and also in the presence of cyanosis. Aminophylline, papaverine, phenobarbital and whiskey, either singly or in combination, may be supplemented to control persistent pain. A readily ingestible and digestible diet is used initially with a fluid intake up to 1500 cubic centimeters daily. Although the bowels may be neglected at the onset, it is important to avoid straining at stool. A low enema, mineral oil or milk of magnesia prevents constipation, distention or impaction.

Thus one recognizes and treats the average case of myocardial infarction. Four-fifths of patients are able to resume former employment. The real problem and the gist of this presentation concern the complications that may arise in the course of an acute myocardial infarction. Verily, these tax the skill, the ingenuity and the experience of the expert.

COMPLICATIONS

Shock: The sudden fall of systolic blood pressure to levels of 70 millimeters or less may result in shock and must be energetically combated. This shock is either cardiogenic (with heart injury) or reflex with hypotension or both. The patient must be kept warm. Continuous oxygen, opiates and stimulants are indicated. Vasopressor drugs should be used immediately. Levarterenol† may be given by slow intravenous drip in a strength of 4 to 32 milligrams per liter. This elevates the blood pressure and increases the peripheral resistance without decreasing the cardiac output and without causing cardiac arrhythmias. Me-

†Available under commercial tradenames as follows. Levarterenol may be given under the Winthrop-Stearns tradename of Levophed.® It is also called l-norepinephrine. Mephentermine is better known under its Wyeth tradename of Wyamine®. Phenyl ephrine is available under the Winthrop-Stearns tradename of Neosynephrine®.

phentermine† 15 to 30 milligrams intravenously or intramuscularly or phenyl ephrine,† 1 milligram intravenously or 5 to 10 milligrams intramuscularly, may be used. If these drugs fail to raise blood pressure, 50 to 100 milligrams of hydrocortisone intravenously should be supplemented to accelerate their action. Plasma, blood transfusions and hypertonic solutions, by increasing the blood volume and by drawing fluid into the blood stream, may precipitate heart failure.

Congestive Heart Failure is treated by the usual methods of oxygen, digitalis, mercurial diuretics and sodium restriction. Over dosage must be avoided to prevent the development of arrhythmias. If sudden acute failure intervenes, the use of lanatoside C or Ouabain® is recommended for more rapid digitalization.

ARRHYTHMIAS

Infrequent Premature Ventricular Contractions require no treatment. If, however, they are numerous, they may be the forerunner of ventricular paroxysmal tachycardia. Quinidine sulphate, grains 3 to 5 (200 to 300 milligrams) every 2 to 4 hours, may be given orally.

Paroxysmal Ventricular Tachycardia is a possible precursor of fatal ventricular fibrillation and must be treated vigorously. Quinidine again is the drug of choice and should be given promptly. The dose is variable. The peak effect of quinidine is obtained within two hours, hence give grains 3 to 9 (0.2 to 0.6 Grams) orally. If no change in rhythm occurs, repeat the dose at two hourly intervals. Check, if possible by electrocardiogram.

Recently, excellent results have been reported from the use of 200 to 1000 milligram doses of procaine amide hydrochloride (Pronestyl hydrochloride®, Squibb) given slowly by vein. Since the intravenous injection of this drug induces hypotension, frequent blood pressure readings during its administration are in order. The oral route may be safer (dosage is 0.25 to 0.5 Grams every 4 hours) because hypotension does not occur when it is given that way.

Supraventricular Tachycardias, Auricular Flutter and *Auricular Fibrillation* are treated with adequate doses of digitalis, quinidine or sedation.

Heart Block: With septal involvement in myocardial infarction, all grades of heart block up to complete A-V dissociation may occur. They may appear transiently for a few days or they may remain permanently. No medication prevents or alters these defects. If complete heart block with Adams-Stokes attacks has occurred, epinephrine,* (0.5 to 1 cubic centimeter of a 1-to-1000 aqueous solution) should be given hypodermically to maintain an effective idioventricular rate and it may require repetition several times a day. Some may prefer isopropyl arterenol,* 10 to 15 milligrams sublingually, which may be repeated 3 or 4 times a day or every 2 hours if indicated. Digitalis is indicated even in high grade block if failure occurs.

OTHER COMPLICATIONS

Rupture of the Heart is relatively uncommon and always fatal.

Rupture of the Interventricular Septum is a rare complication that can be recognized clinically by the development of a loud systolic murmur just to the left of the lower sternum often accompanied by a systolic thrill. If heart failure ensues, digitalization is in order. The condition is not incompatible with recovery and survival for years.

Aneurysm of the Ventricle most commonly occurs in the region of the apex of the left ventricle and is due to the bulging or stretching of the scar tissue resultant from the healed infarct. These aneurysms are of little clinical importance and rarely rupture.

Shoulder-Arm-Syndrome: Persistent pain, stiffness and limitation of motion of the shoulder and arm not infrequently occurs within the first few months after acute myocardial infarction. It is more frequent on the left side but occasionally may occur in the right arm. All forms of treatment have been used

*Commercial tradenames are: Parke-Davis distribute a brand of epinephrine registered as Adrenalin®. Isopropyl arterenol is commercially available under the trade-name of Isuprel®, a product of Winthrop-Stearns.

such as analgesics, diathermy, deep x-ray, local drug infiltration and even upper thoracic sympathectomy. Today, the steroid derivatives achieve prompt relief.

Hiccough is a most disturbing symptom and may be a poor prognostic sign. In addition to carbon dioxide inhalations, morphine may be required. If abdominal distention complicates the condition, stupes and even Wangensteen suction may be resorted to.

Cardiac Neurosis may be a disturbing post-coronary complication. It may change the entire personality of the victim and make him a morose, depressed and melancholy individual. Patient, skillful and time consuming psychotherapy is essential in the rehabilitation program. The newer tranquillizing drugs may help.

Thrombo-embolic Phenomena are among the most dangerous and frequent complications. Extension of the original coronary thrombus may lead to necrosis of areas contiguous to the original infarct. Mural thrombi over the endocardial wall of the infarct may lead to embolization in the brain, extremities, spleen, kidneys or other organs if the site is in the left ventricle; to pulmonary embolism if the primary thrombus is in the right ventricle. Emboli from thromboses in the veins of the lower extremities or the pelvis also are frequent causes of pulmonary embolism.

Anticoagulant therapy has become important in the treatment and prevention of these thrombo-embolic phenomena. These anticoagulants should be started promptly for three reasons: (1) to prevent further extension of the already formed thrombus; (2) to prevent the formation of mural thrombi (a major source of emboli) on the endocardial surface of the infarcted area; and (3) to prevent thrombus formation in the peripheral veins during the prolonged bed rest and inactivity associated with the management of coronary thrombosis. Most of the thrombo-embolic complications occur in the second week, some in the first. They may occur even in the third or the fourth week.

In a study by the American Heart Association of 1031 cases of myocardial infarction, it was found that in every 100 cases there were 41 recognized thrombo-embolic complications of one kind or another. After anticoagulant therapy this was reduced to about 13 per 100 cases as against 41. Therefore it was concluded that if the physician is competent in the technic of anticoagulants and if the laboratory facilities are adequate, the only safe thing is to give anticoagulant therapy to every patient. There are others, on the contrary, who believe that anticoagulants should not be used routinely in every patient who has coronary thrombosis. This group prefers to divide their cases into the good risks who do not receive anticoagulants and the bad risks to whom the drugs are given.

ANTICOAGULANTS

THE combined use of heparin and Dicumarol® seems to be the most common regimen at the present time. The effect of heparin is gauged in terms of its prolongation of the coagulation time of the blood. The effect of Dicumarol® is appraised in terms of its prolongation of the prothrombin time of the blood. Heparin is quick acting, a matter of minutes to a few hours. Dicumarol® is slow acting, the peak effect being attained within 48 hours or longer. Heparin is used the first day or two to cover the lag period of the Dicumarol®. Both the coagulation time and the prothrombin time are determined. If found normal, the two drugs are given simultaneously. The normal clotting time by the Lee-White method is 6 to 8 minutes. Normal prothrombin time has to be determined by each laboratory and usually is around 14 seconds.

Give 50 to 75 milligrams of crystalline heparin intramuscularly every four hours. If depot heparin is used, give 100 to 200 milligrams every twelve hours. Prior to the administration of each subsequent dose, a clotting time is taken to be certain that it does not exceed 20 minutes. If it does, that injection is postponed until the time has fallen to 20 minutes. When the initial dose of heparin is administered, the first dose of Dicumarol® is given orally, usually 200 to 300 milligrams. A prothrombin time is done each morning as the basis

for the next dose. To obtain the optimal therapeutic results, it is necessary to attain prothrombin time levels of 25 to 35 seconds. Average daily dosage of Dicumarol® will approximate 100 milligrams. It may drop as low as 50 milligrams or it may even be omitted for a day.

Another coumarin derivative is available—ethyl biscoumacetate. Distributed under the Geigy trade-name of Tromexan®, this is interchangeable with Dicumarol®. Shift to Tromexan® is advocated because it has less time-lag between administration and action-time. For Dicumarol®, the time is 48 to 72 hours; for Tromexan®, the time is 18 to 30 hours. Tromexan® has the further advantage that, on cessation of the drug, the prothrombin time level reaches normal or near normal levels within 24 hours in contrast to the 48 to 72 hours of Dicumarol®. Tromexan® has almost one-fifth the strength of Dicumarol®, and therefore, the dose is about five times greater.

Dr. Irving Wright recently told me of another combination that he is using with success: 1200 to 1500 milligrams of Tromexan® plus 300 milligrams of Dicumarol® are used initially and then no more Tromexan.® Daily Dicumarol® is continued as dictated by the prothrombin time. If a still more immediate effect is required, give 50 to 75 milligrams of depot heparin every 12 hours.

Since thrombo-emboiic complications may occur even in the third and fourth weeks, anticoagulants should be continued for a full month to obtain the maximal protection. In fact, control experiments on the long term use of anticoagulants in those cases of coronary disease with complications, are in progress and reports should be in the literature in the near future.

Some patients are hypersensitive to coumarin compounds. Pre-existing liver disease may result in diminished prothrombin production which may enhance the effect of coumarin therapy. Vitamin K deficiency also will exaggerate the effect of coumarin drugs. Antibiotics, by mouth, may sterilize the gastro-intestinal tract and reduce the quantity of Vitamin K production. This factor must be kept in mind. Salicylates in large doses may increase the action of the anticoagulants. Since coumarin derivatives are degradation products of salicylates, an increased action can be expected. Acute alcoholism and protein deficiency may alter liver function and accentuate the effect of the anticoagulants.

Conversely, resistance to anticoagulants may occur. It may be idiopathic and some patients will require much larger doses than usual. Malignancy, particularly cancer of the pancreas and of the liver, is a prominent cause of increased resistance to the anticoagulants.

Contraindications to anticoagulant drugs include the blood dyscrasias with bleeding tendencies, serious liver disease and serious renal disease (hematuria and calculi); subacute bacterial endocarditis; ulcerative lesions of the gastro-intestinal tract; severe hypertension, particularly if there is a history of cerebral accidents and the later stage of pregnancy. If the prothrombin time goes to dangerous levels (above 60 seconds), stop the drug, give 72 milligrams of Vitamin K_1 by vein and repeat in four hours. In the face of actual hemorrhage, supplement with a transfusion of 500 cubic centimeters of whole fresh blood. Banked blood is not as satisfactory because, in stored blood, the prothrombin content decreases progressively from the second day on or the accelerator factor decreases which is just as undesirable.

SUMMARY AND CONCLUSION

ACUTE myocardial infarction may be followed by complete recovery and return of the patient to an essentially normal life. Treatment is mostly symptomatic. Specific management of the complications that may arise to plague us is urgently required. Even these may be surmounted and the patient assured a life of future hope and accomplishment.

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Soft Tissue Distress in Rheumatic Disease*

Soft tissue pain, variously described as myositis, bursitis, rheumatism, and so on, is one of mankind's common ills. Dr. Warter suggests a three-fold regime: use of tranquilizing drugs, psychotherapy, and physical therapy. He also reviews the role of specific medication.

In the course of medical practice, every physician is called upon to diagnose and treat what his patients describe as "rheumatism." The term "'rheumatism" is used in medical circles with a confidence born of ignorance. It is a diagnostic wastebasket, responsible for such confusions of diagnosis as "winter rheumatism," "country rheumatism," "psychogenic rheumatism," muscular rheumatism, the various kinds of fibrositis, myositis, tendonitis, bursitis, panniculitis; and we can go on and on in this vein.

Soft tissue rheumatism represents the major complaint in more than one-half the patients seeking medical advice because of rheumatic symptoms. This type of rheumatism is a no man's land, so far as etiology and pathology are concerned.[1] These patients do not have arthritis as exemplified by swollen joints and joint deformity. Their main complaint is that of stiffness and pain, sometimes very severe, which may be localized or generalized.

The most common form of non-articular rheumatism affects the fibrous connective tissue and is designated as fibrositis. Non-articular fibrous connective tissue always shares to a varying degree in the abnormalities which exist in patients who have rheumatoid arthritis. Sometimes fibrositis is the predominant feature. Affection of the connective tissue around osteoarthritic joints accounts for much of the symptomatology of this form of arthritis.[2] It is my concept that almost every crippling rheumatoid arthritis joint had its origin in a soft tissue swelling that would disappear and reappear for many months prior to joint manifestations. These early changes must be given serious consideration and the benefit of medical treatment.

Fibrositis, for the sake of clinical differentiation, can be divided into two categories: primary and secondary.

Primary fibrositis may be sharply localized, or rather generalized. Separate types of anatomic primary fibrositis are recognized: intramuscular or muscular rheumatism; myositis; tendonous fibrositis; perineural fibrositis, also known as "neuritis" or "neuralgia"; periarticular fibrositis or capsular rheumatism; bursal fibrositis or bursitis; and panniculitis or fibrositis of subcutaneous fibrous tissue

Panniculitis is out of place in the fibrositis group. It represents an irritation of the panniculus adiposus (superficial fascia with fatty deposit in the areolar substance). It occurs in spotty locations

*Read before the Section on Rheumatism, Annual Meeting of The Medical Society of New Jersey, May 15, 1956.

1. Holbrook, W. P.: G. P., 6:53 (Nov.) 1953.
2. Freyberg, R. H.: Bulletin of the New York Academy of Medicine, 27:345 (Apr.) 1951.

and usually at menopause.[2] The symptoms and signs are: (a) localized areas of induration with tenderness; (b) localized areas of rapidly increasing adipose tissue, usually associated with increase in general body weight; (c) increase in depth of collagen layer, and (d) water retention. The localized areas of distress are associated with hypcresthesia, induration, and mottled appearance. The areas which may be involved are the malar or parotid, outer aspects of the thighs, each side of the tendo achillis, low back, buttocks, subdeltoid area, anterior portion of the thighs and calves of the legs, and the nape of the neck. The incidence of this syndrome was 0.5 per cent of females presenting themselves in two rheumatic clinics.

The treatment of panniculitis consists of estrogenic substances, Meticorten® and phenyl butazone† (if water retention is not present), weight reduction and exercise. The disease eventually disappears with weight loss. Otherwise it persists.

Secondary fibrositis is manifested as part of an associated disease. Secondary fibrositis is very likely to be passed by or overlooked in many cases because of attention being directed to more painful symptoms. Susceptibility may be enhanced by physical or emotional trauma, environmental factors, dietary deficiencies, infections and fatigue.

Thus it is apparent that it would be of advantage to look upon fibrositis as a syndrome with a wide variety of causes rather than a definite clinical entity.

Many physical symptoms may have emotional causes. We have all seen symptoms which, we felt, were due to emotional tension. We might then dismiss the complaints as "neurotic." This, no doubt, reflected our inability to cope with the problem: such advice would have profited the patient therapeutically.

The psychosomatic effect would appear to be a local neuromuscular or vascular disorder with tautness in the muscles which seems to come and go with the rise and fall of emotional tension. In some way, this hypertonicity must stimulate the muscle pain mechanism to produce the aching and tenderness and incite nerve reflex mechanisms to produce the trigger points and referred sensations.[4]

By whatever criteria we measure the behavior pattern of the patients with fibrositis, we seem to arrive at the same general conclusion: that many of these individuals have apparently been conditioned from early childhood to live with a taut and tense skeletomuscular system as well as a capillary system under intermittent constriction. These phenomena are affected by emotional states which hyperactivate the hypothalamic vegetative system and the adrenals. It is not our desire to add to the already confused state of the subject under discussion, but we might be justified in coining a new term and in future discussions refer to our subject as "hypothalamic rheumatism."

Except in the aged, it is quite probable that most patients with generalized fibrositis can much better be described as having an anxiety state in which the pain and symptoms represent a normal physiologic fatigue process from tension.[1]

FATIGUE is probably the greatest factor in the genesis of disease. Fatigue should be given serious consideration in the management of this problem. Fatigue may be manifested by such sensations as weariness, lassitude, and a decreased capacity for physical or mental tasks. These phenomena are a reflection of the body's inefficiency from a functional aspect, and an indication of its susceptibility to injury.

The individual is a museum of delicately balanced physiologic reactions. Any break in this physiologic balance may lead to permanent tissue damage and even invalidism. The symptoms manifested are an expression of the body's attempt to re-establish balance. The time required by the body to make such adjustments will determine the duration of the disease.

When an individual is repeatedly subjected to environmental patterns which are unsuited to his temperament and concerning which he develops an anxiety tension state, his fear causes him automatically to go on guard.[5] Fear produces muscle tension. This leads to what has been termed neuromuscular hypertension,[6]

†We use the Geigy brand of phenyl butazone trade-named as Butazolidin®.

3. Baker, D. M.: Annals of Rheumatic Disease, 14:385 (July) 1955.

4. Graham, W.: Bulletin of Rheumatic Diseases, 3:33 (Apr.) 1953.

5. Dixon, H. H., Peterson, R. D., Dickel, H. A., Jones, C. H. and West, E. S.: Western Journal of Surgery, 60:327 (July) 1952.

which appears to be related to the fatigue state. Fatigue produces weakness which reduces the threshold at which effort produces fatigue. Tension does not allow the muscles to relax. Under tension with spasm every motion is a force against a residual spasm which eventually produces varying degrees of tissue injury. Oft-repeated minor trauma becomes a major injury. The consequence of any injury is impairment of a body's ability to react to changing conditions with its usual responsiveness. The result of injury, obviously is pain, which tends to disturb the entire physiologic balance of the individual.

The integrity of the capillary system has received very little or no consideration as a factor in fibrositis. We have pointed out that soft tissue changes associated with rheumatoid arthritis affect the normal integrity of the capillary system. It has been established that almost any type of trauma, be it physical, chemical or psychic, will adversely affect the capillaries.[7] Normal physiologic functions cannot be carried out in the presence of a faulty capillary system, which results in dysfunction in the areas involved. Poor blood flow in the vasa nervosum as a result of impaired capillary structure is a causative factor in pain related to the arthritides and the soft tissue changes discussed.

TREATMENT

IN THE management of soft tissue rheumatism or fibrositis, the physician must be careful not to latch onto one etiologic factor which appears to have an undisputed connection with a particular symptom complex and to call its environmental biologic relation absolute. A multiplicity of factors is involved in this syndrome.

We are called upon to alleviate pain and to relieve the anxiety state. These patients are fearful, apprehensive, and at times very unstable. A detailed history of their background (family, associates, religion, economic status, nature of work and so on) is essential.

The patient must be viewed and treated as a total entity, and not as a single symptom. The patient's problems should be of as much importance to the physician as they are a concern to the patient. A tense and anxious patient is not in a favorable situation to understand totally the physician's explanations on his first visit.

The response of the patient to a therapeutic program will be more profitable if he can be conditioned to positive thinking. The patient's desire to get well is the crux of a successful therapeutic program.

Rest is the basis for sound treatment. It should be of such duration as to aid in the recovery of physiologic equilibrium. Every effort should be made to relieve the factors causing apprehension and emotional strain. Bed rest is not required. Injury must be avoided at all times. Local rest is provided by means of elastic supports, braces and casts. One of the most efficacious ways of accomplishing rest is to establish the patient's "fatigue time." Individualize this procedure if possible. The patient must find the period of time it takes muscles to become tired while doing the average work expected of them. Then in the ensuing hours of the day, the patient must stop short of this time and sit, *doing absolutely nothing* for about ten minutes. This procedure must be repeated by the clock throughout the day. It may be difficult for a patient to establish a time factor. It is suggested the program start with arising. After an hour, rest for five minutes, and continue to do so throughout the day, every day. For obvious reasons this schedule is not feasible for those engaged in assembly line jobs, industrial workers, and others. In these cases, a reasonable substitute is a forty-five minute rest period upon arriving home from work. The rationale for observing fatigue time is to avoid the use of muscles when they are in a state of fatigue.

Physiotherapy is a valuable adjunct in the treatment of these problems. Judicious use of

6. Jacobson, E.: *Progressive Relaxation*. Univ. of Chicago Press, Chicago, 1947.

7. Warter, P. J., Drezner, H. L. and Horoschak, S.: JOURNAL of The Medical Society of New Jersey, 43:228 (June) 1946. *Also*: idem, Delaware State M. Journal, 20:41 (Mar.) 1948.

the various physical aids is necessary. Proper exercise, passive and active, is required for muscle rehabilitation. The patient must be made to understand that the anxiety tension state is an alerting process and that physical exercise is useful in altering the tension state to one where the neuromuscular energies have been released and physical relaxation is more likely to result.

Work Consideration. Recovery from rheumatic problems is enhanced if treatment is carried on while the patient continues to work. This is usually possible. The patient must be taught to eliminate all extra and unnecessary efforts which involve the skeletal-muscular system as a whole, especially the affected parts. He must be made to realize that 30 to 35 per cent of motion in a 24-hour period is unnecessary. These additional work loads should be eliminated systematically. The use of single group muscles, such as the forearms alone, should be replaced by the use of multiple groups, such as arms, shoulders, neck, chest, and back muscles as a unit.

THE relief of anxiety and tension states is possible by the use of a combination of 250 milligrams of propyl dioxolane* and 0.25 milligrams of reserpine in an enteric coated capsule. This combination relaxes the patient adequately, and aids him in controlling the subconscious actions of the use of muscles. The tranquilizing effect is more profound than that obtained with either drug alone. In the more severe rheumatic problems, it has been of much aid in supplementing other therapy. Prescribe one capsule after meals and one at bedtime for ten days to two weeks, then continue the patients on one capsule after breakfast and two at bedtime.

It is much easier to "get to" a patient who is relaxed and feels more at ease. There are times when we find a patient with a psychotic or severe neurotic disturbance instead of what appeared to be a minor rheumatic problem. This must be recognized, and treatment by a psychiatrist initiated

The most urgent problem to the patient is the relief of pain. Salicylates remain the drug of choice. My preference is aspirin. The newer chemical agents and steroid forms of therapy have a definite place in the treatment of certain forms of arthritis. But no combination of steroids and salicylates in one tablet or capsule ("high powered aspirin") should be used. Neither drug can be controlled in this manner.

To correct capillary fragility and permeability I use a combination of hesperidin (100 milligrams) and ascorbic acid (100 milligrams) in capsule form. Results with this combination have justified the decision to incorporate it into our over-all management of the rheumatic and arthritic problems. An intact capillary system is essential for the restoration of normal physiologic functions. For this reason we strive for normal capillary resistance in these patients.

The local use of hexylcaine‡ or procaine by infiltration into a "trigger-point" area is frequently a rapid aid in relieving localized tenderness and hyperesthesia. This is paticularly true in acute peritendonitis, which is often relieved by means of a brachial plexus block or a stellate ganglion block (anterior approach). These agents used interarticularly for distress due to soft tissue injury in and about a joint often produce dramatic results and when combined with Hydrocortone®, longer lasting relief is the rule.

Fear accelerates the metabolic and especially the catabolic processes of cells. We are also aware that worry will dissipate energy. The deprivation of biologic essentials accompanied by stress situations beyond the threshold of tolerance definitely enhances the disease state.

On the other side of the ledger we have the obese patient in whom dietary measures are necessary for weight reduction.

We are using an intact protein preparation of high biologic value‡ as a supplement to the patient's diet. This is well tolerated and has met with patient acceptance.

*Commercially available under the brand name of Dimethylane® (National Drug Company).

‡Hexylcaine is available under the Sharp and Dohme brand name of Cyclaine®. The protein preparation is tradenamed as Protinal® and distributed by National Drug Company.

CONCLUSIONS

1. It is necessary that fibrositis be recognized for what it is: a disease of unknown etiology and bizarre pathology.

2. Reassure the patient that you know what you are dealing with, and that as time passes you will make every effort to advise the patient so that he will understand his condition and carry out all instructions.

3. Make every effort to realize a relaxed state in the shortest possible time through the following methods: propyl dioxolane* with reserpine, psychotherapy and physiotherapy. Thus the tense patient will experience some degree of ease, so essential for his welfare.

4. Treat the patient as a human being. Treat him as well as his disease. It is the duty of the physician to guide the patient, and it is nature's duty to heal.

40 Parkside Avenue

Emergency Treatment of Soldiers and Sailors

Upon acceptance by a hospital or physician of an individual in the military service (Army, Navy or Air Force), immediate report should be made to the nearest military facility. This procedure should be accomplished whether the individual is absent with or without leave. If the individual is in an AWOL status, the report of his location and illness or injury constitutes a return to military control and terminates his AWOL status. *The government subsequently becomes responsible for payment of his medical care by civilian agencies.* These statements apply to practically every situation except those unusual cases in which an individual is engaged in a criminal act or when unauthorized medical care is furnished for a condition that is not an emergency. The assumption must be made that one service will act for the other in the matter of relaying the information to the parent organization.

Statements of account for payment may be forwarded to the individual's commanding officer who will transmit them to their proper destination. The processing of an account involves a matter of weeks but *payment is certain when emergency medical care is rendered a bone fide member of the military service who is not AWOL and who is not engaged in a criminal act.*

If further inquiry is desired, address correspondence to Surgeon, First Army, Governors Island, New York.

Tri-Ethylene Thiophosphoramide

J. C. Bateman (New England Journal of Medicine, 252:879, 1955) found tri-ethylene thiophosphoramide (a nitrogen mustard-like compound) helpful in carcinomas. The agent was used in 99 patients with a variety of far-advanced carcinomas. The agent was administered by various routes, including direct injection into tumor masses, in individual doses of 5 to 30 mg., depending on route of administration. Clinical improvement of varying degree occurred in 80 per cent of patients. It is not likely that tri-ethylene thiophosphoramide will prove to be a cancer cure-all but it is a useful palliative agent especially in breast and ovarian cancer.

Shay and Sun report similar results with tri-ethylene thiophosphoramide in treatment of inoperable cancer (Cancer 8:498, 1955). Zarafonetis, *et al.,* found the agent of value in management of chronic leukemia. (Cancer 8:512, 1955).

Carl P. Guzzo, M.D.

Orange

Carcinoma of the Pancreas

In 1955, the Harrison Martland award of the New Jersey Anatomic and Pathologic Society was won by Carl P. Guzzo, M.D. for a 14,000 word monograph on the embryology, anatomy, pathology and diseases of the human pancreas. The paper below is one section of that prize essay.

In the pancreas, the commonest type of malignancy is an adenocarcinoma. Sarcoma and lymphosarcoma rarely involve the pancreas. The tumor may involve the gland anywhere. Usually it implicates the head of the pancreas. Resection of the head is required. If local metastases have occurred beyond the limit of resection, 2,000,000 volt x-ray may be used for palliation. Carcinoma is present in 0.1 to 0.75 per cent of all autopsies and comprises 1 to 2 per cent of all carcinomas. It causes 1 to 2 per cent of all deaths from carcinoma. Two-thirds of the cases occur in the head of the pancreas. Carcinoma of the ampulla occurs in 0.09 to 0.2 per cent of autopsies. It occurs between the ages of 40 to 70, and is more frequent in men, by a ratio of two to one.

Symptoms: The prime symptom is dull epigastric pain with radiation to the back. It is progressive in its severity and aggravated by eating and recumbency. It may be partly relieved by sitting up and bending forward. Weight loss is common and is extreme. Anorexia and nausea and diarrhea or constipation are frequent. Jaundice occurs in 75 per cent of the cases. In carcinoma of the head, the onset is insidious, after several weeks of systemic symptoms. Jaundice with carcinoma of the ampulla of Vater comes on rapidly and appears before weight loss. Fatigue is an early symptom of carcinoma of the pancreas but is less prominent in the early stages of ampullary carcinoma. Diarrhea occurs in 16 per cent of ampullary carcinomas but in 46 per cent of resected cases of carcinoma of the head. Constipation and diarrhea occur with equal frequency in carcinoma of the head of the pancreas.

Examination: Jaundice is noted in 75 to 80 per cent of cases of carcinoma of the head. It is associated with enlarged liver. The gall bladder is palpable in 30 to 60 per cent of carcinomas of the head or ampulla. A firm, fixed, palpable tumor occurs only in the late stage. Recurrent migratory phlebitis is noted in the lower limbs.

Laboratory: Hyperbilirubinemia, an elongated alkaline phosphatase, elevated cholesterol, hyperglycemia, glycosuria, excess fat and undigested meat in the stools are the usual findings. Duodenal drainage may reveal malignant cells, especially in ampullary carcinoma.

X-ray: Enlargement and displacement of the duodenal sweep is the looked-for-sign. The inverted "3" sign *i.e.*, indenture of the medial aspect of the duodenal mucosa is also seen. Obstruction of the duodenum is noted in advanced cases. The doctor must differentiate between carcinoma of the pancreatic head and ampulla. Carcinoma of the head is characterized by an insidious history of weight loss, abdominal pain, bowel symptoms, and jaundice. Carcinoma of the ampulla is characterized by

rapid onset of jaundice, painless anorexia, weight loss and much less disturbance in bowel function.

Pathology: Carcinoma of the pancreas proper is ductal in origin but may arise from acinar tissue, more rarely from islet cells. Islet cell carcinoma may (or may not) produce insulin. Carcinoma of the pancreas shows a common tendency to perineural invasion and fibrosis. On microscopic section, most are adenocarcinomas or carcinoma simplex. An occasional squamous carcinoma may be found. As tumors grow, they obstruct the duct of Wirsung and the distal common duct and later may spread to the duodenum. Secondary spread in addition to direct extension, occurs by way of the lymphatics and blood vessels. Carcinoma of the head travels by way of the distal ducts.

Treatment: In operable cases, the treatment is radical pancreatico-duodenal resection. In others, there may be palliation by cholecystojejunostomy or pancreaticojejunostomy.

258 Reock Street

Alcohol in Arteriosclerosis Obliterans

Beverage alcohol is beneficial in arteriosclerosis obliterans, Dr. J. Earle Estes, Jr., of the Mayo Clinic, states in *Minnesota Medicine* (39:203-207, 1956). He recommends two ounces of beverage alcohol four times a day. He says that in addition to its vasodilating effect, the alcohol has a sedative effect and produces a feeling of well being.

"At times," he continues, "alcohol may be given intravenously as a 5 per cent solution, the rate of infusion being regulated by the effect on the patient."

While lumbar sympathectomy is sometimes attempted to improve blood flow, Dr. Estes finds that surgery is contra-indicated for many elderly patients. Instead, he says, "in recent years, surgeons have attempted to produce chemical sympathectomy by injecting the lumbar ganglia with absolute alcohol."

Other ways of obtaining increased blood flow, according to Dr. Estes, include the use of an oscillating bed or of a special hot box placed over the extremities. However, he adds, such devices are frequently not obtainable outside of hospitals.

To relieve the symptoms of arteriosclerosis obliterans, Dr. Estes recommends the use of "the simplest drugs first, such as barbiturates, aspirin and codeine," although it may later be necessary to try opiates. He emphasizes that great care must be taken in the care of the feet to avoid ulceration and gangrene.

A Time to Help

A busy executive leaves his desk, a corner shop keeper locks his front door and adjusts a sign to read "back at two o'clock." A plant foreman changes into street clothes, a young mother gives one last word of caution to the baby sitter. A teacher joins a student, a nurse stops by to give a neighbor a lift. All ages, all professions or jobs, all interests are represented when a united community campaigns volunteer meeting is called.

Millions of such volunteers are assembling now in cities and towns all over the United States and Canada. A campaign to raise over 340 million dollars is their immediate project. Some 23,000 local, state and national agencies depend on this once-a-year campaign to pay the costs of their services . . . health, recreation and family welfare services that benefit an estimated 63 million people.

Scouts, Visiting Nurses, Red Cross, USO, neighborhood centers, summer camps, hospitals, clinics, family counseling services, research programs . . . all contribute to wholesome, healthy community life. Volunteer workers, inspired by an intense desire to contribute to that way of life, make these services possible.

Everybody is needed. Everybody can volunteer. Offer your help, today, to your town's United Fund or Community Chest.

Marcel A. Mersch, M.D.
D'Arcy Clarie, M.D.
Leo J. Fitzpatrick, M.D.
Teaneck

Methitural in General Surgery and in Obstetrical Anesthesia*

Methitural is a short acting thiobarbiturate. Given intravenously or as continuous drip, it was found to possess many unique advantages for obstetrical and for surgical anesthesia.

The most hopeful of recent advances in anesthesiology is in the field of intravenous anesthesia. A well-conducted intravenous anesthesia has several manifest advantages. These include: (1) the rapidity and ease with which an anesthesia may be induced; (2) controllability of the dosage range; (3) the short recovery period; (4) time-saving for the anesthesiologist; (5) it is an aid to the surgeon in that the anesthesiologist may be located away from the surgical field. This is especially desirable in head and neck surgery.

The first clinical studies [2] in the use of thiobarbiturates appeared in 1935. Since then, thiobarbiturates as anesthetic agents have enjoyed widespread popularity. Many critical analyses [3] of these agents have been published. Methitural sodium [1] is a new ultra-short acting thiobarbiturate anesthetic agent. It was introduced in Europe [4] as "Thiogenal" and was given exhaustive clinical study [5] in over 10,000 cases. It was reported as without adverse effect on respiration, blood pressure or pulse rate. Recovery from ten minute operative procedures was complete between 15 and 30 minutes, with patients mentally alert and ready for discharge.

CHEMISTRY

Methitural sodium [1] is unique among members of the thiobarbiturate anesthetics in that it has a second sulfur molecule in the substitution, in a special methylthioethyl radical. This methylthioethyl side chain is also present in methionine, one of the essential amino acids. Methionine has a protective action on the liver, protecting it from hepatoxic agents.[6] Adrian [7] has shown the basic relationship of thiobarbiturate drugs to the basic barbiturate formula.

Methitural [1] is a pale yellow, very hygroscopic powder containing anhydrous sodium carbonate. It is freely soluble in water or ethyl alcohol. In solution without sodium carbonate, it is clear with a pale yellow color and a pH of 9.8. It is slightly

*This work comes from the Anesthesia service of the Holy Name Hospital in Teaneck. It was read May 15, 1956 before the Section on Anesthesiology of The Medical Society of New Jersey.

1. Tradenamed as Neraval®, this drug is commercially available through the Schering Corp., Bloomfield, N. J.
2. Lundy, J. S.: Proceedings of the Staff Meeting of the Mayo Clinic, 10:535 (Aug. 21) 1935.
3. Tovell, E. *et al.*: *Anesthesiology*, 16:6 (November) 1955.
4. Riefferscheid, M. and Dietmann, K.: Deutsche Medizinische Wochenschrift 79:638 (April 16) 1955.
5. Dietmann, Karl.: Deutsche Medizinische Wochenschrift, 79:1748 (Nov. 19) 1954.
6. Boone, Joel *et al.*: Anesthesiology, 17 284 (March) 1956.
7. Adrian, J.: *The Chemistry of Anesthesia* Springfield, Illinois 1946 Charles C. Thomas Company.

less alkaline than thiopental and thiamylal. Atropine, morphine, succinylcholine and d-tubocurare are compatible with methitural.[1]

The anesthetic potency of methitural[1] in dogs, cats and monkeys is two-thirds that of thiopental.[8-9] However, equivalent anesthetic doses show that methitural[1] was as efficient an anesthetic agent as thiopental and that recovery was significantly more rapid. Cumulative action of methitural[1] was negligible in comparison with the older drugs. Daily administration of methitural[1] for more than a month apparently does not produce tolerance nor cumulative effect.

No abnormal neurologic or hematologic changes, impairment of liver or kidney function, nor gross or significant pathologic changes in the tissues were noted. As reported from Europe[9] there was notable absence of vertigo, salivation, vomiting, weakness, tremors and excitement during anesthesia and recovery. Mild coughing was observed. This was also noted in our own clinical studies. It was found possible to control this by regulating the speed of injection and also by diminishing the concentration of the drug.

CLINICAL STUDIES

SINCE we received our supplies of methitural[1] a little over one year ago it has been our intention to study this drug in every form of clinical problem. Special effort was made *not* to use it in only selected cases. It was decided to give methitural[1] application tests under the everyday routine anesthesiologic activity of a moderate size community hospital. It was put to use under a variety of circumstances. We used it in cases where one would select an intravenous anesthetic as agent of choice.

Premedication routines were not altered in any way. This was to make the clinical trials more closely approach the ordinary use of the older drugs. It has been our policy to premedicate our patients according to the usual criteria of pain, fear, apprehension and the possibility of occurrence of undesirable reflex activity. Therefore, these patients were premedicated with many combinations of morphine and scopalamine; or atropine, meperidine† and scopalamine or atropine. These combinations were sometimes used with barbiturates. In general, the premedicants were given one hour before operation began. If there was any barbiturate premedicant involved this was usually given one and one-half hours pre-operatively.

To acclimate ourselves to the use of methitural[1] we originally used the agent as an induction medium. For this purpose it was used in a suggested concentration of 10 per cent.[5] This concentration was given to patients in single injections supplemented with a variety of agents such as nitrous oxide, cyclopropane and ether. The usual effective dose was found to be in the range of 300 to 400 milligrams. It was effective for short procedures such as curettages, drainages, incisions and cystoscopics. Duration of action was usually ten to fifteen minutes. However, if the injection of the agent was too rapid, the patient had a mild coughing spasm. This was controllable by slowing down the rate of injection and altering the concentration to 5 per cent methitural.[1] This technic was used in 450 obstetrical cases. These patients were in most instances supplemented with nitrous oxide with the occasional addition of minute amounts of ether. It appeared that the induction with methitural[1] markedly decreased the necessity for anything but the smallest amount of ether in supplementation with nitrous oxide. Results were gratifying. Although the interval between the injection of methitural[1] and the actual time of the birth was covered from two minutes to in excess of thirty minutes (with practically all intervals in-between represented) there was not found to be any significant depression of the infantile respiratory apparatus. The reasons for this are not clear at this time but we are now in the process of trying to measure the concentration of methitural[1] in the placental blood and compare it with the dose given originally.

We used 5 and 10 per cent methitural[1] in connection with a variety of endotracheal technics. It was used for intubations as an agent for induction and in combinations that included cyclopropane, succinyl choline followed by nitrous oxide or ether and tubo-curare supplemented with any of these agents. Methitural[1] was totally compatible with these muscle relaxing agents.

†For meperidine, we used the Winthrop-Stearns brand, tradenamed Demerol®.

8. Bunka, Heinrich: Prinzmetal Praxis (Schewize Arkives von Berne) 6:2 (Oct. 30) 1954.

9. Scherer, C.: Medizinische Klinike (Berlin) 49:923 (June 4) 1954.

Methitural[1] was also used in a concentration of 5 per cent for induction in an attempt to get away from the sometimes undesirable coughing spasm. It was found to be equally effective in the dosage ranges and technics above described. In a few cases we found some difficulty with venous irritation with the use of the 10 per cent solution. However, for all practical purposes this was eliminated with the use of the 5 per cent solution.

To give this anesthetic a fair trial as an agent for basal narcosis we undertook to use it in a continuous drip solution. It was decided to use methitural[1] in a concentration of 5 Grams per liter of solution. This is a 0.5 per cent solution. It was found to be compatible with any of the usual intravenous fluid combinations.

The technic we followed was simply to initiate anesthesia by starting the intravenous solution and allowing it to run freely through an eighteen gauge needle. The patient was observed for loss of eyelid reflex, quiet, even respiration and a relaxed jaw. At this point, small amounts of analgesic anesthetic agents were added. We found that by regulating the flow rate of the solution we could control and maintain anesthesia with the supplementation of only nitrous oxide-oxygen combination for those surgical cases which did not require maximum relaxation of muscles. Many of these procedures lasted extended periods of time. The continuous drip of 0.5 per cent methitural[1] solution was found to be compatible with all endotracheal technics. It was found to be compatible with the simultaneous introduction of succinyl choline solutions in patients who required muscle relaxation or the intermittent injections of muscle relaxants such as tubo-curare.

As an agent for the supplementation of regional technics where it is desirable to have the patient in an attitude of sleep it was most satisfactory. This was accomplished by using the continuous drip method and regulating the rate of flow according to the patient's response.

Two interesting cases of eclampsia were subjected to methitural[1] as an agent of sedation. It was used as a 0.5 per cent solution continuously for 28 hours to a total in excess of fifteen Grams in one case. This patient was most satisfactorily sedated: by regulating the flow of solution, she could readily be aroused. This procedure was begun on this patient when she was having a convulsive seizure. The patient remained without convulsions until the time was considered right for cesarean section. The cesarean was done using as anesthetic a continuation of the methitural[1] drip solution supplemented by nitrous oxide-oxygen anesthesia. The baby was delivered without respiratory difficulty. Mother and baby made an uneventful recovery. The second case was similar but the severity of the case was said to be lessened. However, the results were identical.

COMMENT

Methitural (Neraval®) was found to be a satisfactory agent for induction and maintenance as a basal narcotic. It was given a wide clinical application and put to many tests. The most outstanding characteristic of this drug is the rapidity with which patients emerge from the anesthesiologic state. Patients are awake and in contact with their surroundings in very short periods of time. It is in this connection that its use in an emergency room of a hospital for short quick procedures is justified. These patients have adequate anesthesia with excellent recovery times. Its use is justified with out-patients for this reason.

Although methitural[1] was used in many concentrated forms we feel that its ideal concentration rests between 1 and 5 per cent. We have been using it in a 2.5 per cent concentration. It necessitates the injection of larger quantities of fluid but this does not appear to be a disadvantage. Results have been identical with those already described. The irritating properties such as coughing and venous irritation have been largely eliminated with the use of this lesser concentration.

The continuous drip solution, as a 0.5 per cent concentration, has proved a valuable adjunct to intravenous anesthesia.

Methitural[1] (trade-named as Neraval®) can be used wherever the choice of an intravenous agent seems ideal. However it is subject to the same technicologic and medical con-

tra-indications as are commonly associated with intravenous anesthesia.

SUMMARY

A NEW short-acting thiobarbiturate anesthetic has been studied. This is methitural,[1] commercially available under the trade-name of Neraval®. It was found to exhibit the following salient features:

1. Diminished cumulative effects and extremely rapid and complete recovery.
2. Its use on ambulatory patients for brief procedures allows their discharge in 30 minutes due to the rapid recovery time.
3. Used in over 400 obstetrical cases for induction purposes, methitural[1] did not cause any significant infantile respiratory depression.
4. Side effects such as mild coughing spasms, hiccoughs and venous irritation were largely eliminated by controlling rate of injection and diminishing concentration of the methitural[1] solution.
5. Especially gratifying was its use as a continuous drip for basal narcosis. The optimum concentration for this use is 0.5 per cent solution.

167 Belmont St., Englewood (Dr. Mersch)

A Personal Health "Log"?

Every citizen should have a personal health log. So suggests Dr. Carl A. Dragstedt of Northwestern University in the April 14 (1956) issue of the Journal of the American Medical Association.

"What everyone in this country needs," he said, "is a good personal health log. By that I mean a suitable booklet in the permanent possession of everyone, in which would be recorded some of the important aspects of his health record, encompassing items from his family history, and data on such things as his vaccinations and inoculations, his diseases and operations, his blood pressure, blood cell counts, and similar laboratory findings. It would be for him, and all of his contacts with hospitals and physicians, somewhat comparable to a permanent passport for travelers. Upon consulting a physician or entering a hospital, he would submit his health log. This would save considerable time now consumed in taking his history and would have the added advantage of being much more accurate and reliable than the frail memory of an anxious patient. Upon the termination of his illness, the log would be returned to the patient.

"The American citizen pays a considerable amount of money to get well and to keep well . . . Upon settling up with his hospital or his doctor, the patient's log would be returned to him, brought up-to-date as to salient items regarding what was found and what was done. As it is, I dare say that for a great many people in the United States there is much information that has been gathered incident to sicknesses, hospitalizations, and periodic health examinations that is scattered amongst various hospitals and doctors' offices and becoming more and more inaccessible with time."

Dr. Dragstedt said the book should be durable enough to last a lifetime and should be about 4 by 7 inches in size, so it could easily be kept with other books on a shelf and yet be carried on occasion in the pocket or purse. Dr. Dragstedt thought that agreement on exactly what should be included in the book could easily be worked out.

Almost every baby born in the last 10 years has been launched with a baby book, which has space for information about inoculations and vaccinations. They have proved "extremely serviceable" during the childhood years, but in few instances have they been continued, he said, concluding:

"The idea of the log book is thus not entirely new, but is merely an extension and amplification of one that seems to have worked rather well in a limited field."

J. C. Breme, M.D.

Laurel Springs

Pulmonary Hypertension

Here is a girl with a left-sided cardiac lesion, not identified, which is causing elevated pressures throughout the whole lesser circuit. What is it?

Only since the introduction of cardiac catheterization, has it been possible to diagnose pulmonary hypertension with certainty and to make an exact estimate of its degree. Here is a case presenting some unusual and interesting facets which are not readily apparent as in many cases of pulmonary hypertension where the cause is obvious.

A 14-year old girl was admitted to West Jersey Hospital for evaluation of a heart murmur discovered by her family doctor in 1952. There was no previous history of cardiac or pulmonary disease, nor did the patient suffer any symptoms associated with cardio-pulmonary diseases. Growth and development during infancy, childhood and adolescence had been normal.

All physical findings were normal except those referable to her cardiac status. Right arm blood pressure was 124/80; right leg, 144/110. There was no obvious orthopnea, exertional dyspnea, cyanosis or clubbing of digits. Her cervical vessels were normal. Peripheral pulses were palpable and bilaterally equal with no edema or hepatic enlargement or tenderness. The lungs were clear. Grossly there was no cardiac enlargement and no thrills were present. On auscultation, there was a harsh, medium-pitched grade 2 or 3 murmur at the second left intercostal space occupying practically all of systole without significant radiation. Her pulmonic second sound was moderately increased and pure.

There were no electrocardiographic abnormalities and the hemogram was within normal limits.

Fluoroscopy revealed slightly increased pulmonary vascular markings with normal pulmonary artery pulsations and a normal G point. Preliminary radiologic heart films show 1-plus pulmonary vascular markings and 1-plus enlargement of her pulmonary artery segment. Right ventricular inflow and outflow tracts were enlarged 1-plus.

Intracardiac catheterization results are recorded in the accompanying table. The right ventricular and right atrial blood values are a mean of three samples from each chamber. Mean pressures are in parentheses.

Brachial artery saturation was 93 per cent, oxygen consumption was 154 cc./min. and pulmonary vein saturation was assumed to be 96 per cent. From the above data the following may be calculated:

Cardiac output—4.97 L./min.
Cardiac index—3.08 L./min.
Systemic blood flow—4.05 L/min.
Pulmonic blood flow—4.2 L/min.
Effective pulmonic blood flow—3.5 L./min.
Total left-to-right shunt—0.66 L./min.
Total right-to-left shunt—0.54 L./min.
Pulmonary arteriolar resistance—
177 dynes/sec/cm^{-5}
Total pulmonary resistance—
482 dynes/sec/cm^{-5}

TABLE

	P.V.C.*	I.V.C.	S.V.C.	R.P.A.	M.P.A.	R.V.	R.A.	Inn.	B.A.
Blood (Vol. %)		14.7	14.3	14.1	14.7	14.1	14.2	14.8	17.8
Pressures	(19)			31/18	47/20	52/12	(10)		164/100
				(26)	(30)				(124)

*Note: It is possible that the P.V.C. pressure is reflecting pulmonary artery pressure and is not a true venous pressure.

Although clinical, laboratory and physiologic data do not correlate perfectly, the pressures are elevated in the entire lesser circulation from the atrial level, to and including pulmonary wedge pressure. It is, of course, possible that the PVC pressure is reflecting a pulmonary artery pressure and is not a true venous pressure. However, on the basis of an elevated pulmonary venous capillary pressure alone, it is untenable to entertain a diagnosis of primary pulmonary hypertension. These elevated pressures must be a reflection of a left-sided cardiac abnormality or of some, as yet unmanifested, disease of the pulmonary structure.

RIGHT ventricular endiastolic pressure is considerably elevated, as is right atrial pressure, yet the patient shows no symptoms or signs of right heart embarrassment and the electrocardiogram shows no evidence of right heart strain. If we go further and look at the pulmonary arteriolar and total pulmonary resistances it then becomes apparent why the the electrocardiogram shows no strain pattern in the lesser circuit. It has been established that total pulmonary resistance must be elevated to 1000 dynes/sec/cm^{-5} for an electrocardiogram to show evidence of right heart strain in a left-sided lesion.[6]

There is a disturbing factor present in the blood oxygens. Main pulmonary artery oxygen was reported at 14.7 volumes per cent and right ventricular oxygen at 14 volumes per cent. This would suggest the possibility of a patent ductus arteriosus, aortic-pulmonic fenestration or rupture of an aneurysm of the sinus of Valsalva into the right ventricle (although elevated pulmonary artery and right ventricular diastolic pressures would tend to eliminate aneurysmal rupture).[7] This is not supported by clinical findings in that there was no diastolic component to the murmur. It is not probable that right-sided pressures are high enough to eliminate a diastolic murmur. I believe this to be a technical error.

Systemic blood flow and pulmonary blood flow are very nearly equal and total L to R and R to L shunts are so small as to be insignificant.

Considering the elevated pressures in the pulmonary circuit one would expect to find on fluoroscopy and x-ray considerable increase in pulmonary artery pulsations and right ventricular enlargement of a greater degree than is present. It is probable that the pulmonary hypertension has not come of age as yet, but that future radiologic studies may show what we would expect to find and what ultimately must come to pass.

Even though the brachial artery pressure was somewhat elevated there was no roentgen or electrocardiographic evidence of strain in the major circuit. Further, it was agreed by several examiners that the murmur did not clinically represent a left-sided lesion.

Although it is not always possible to rule out a ventricular septal defect even with cardiac catheterization, it would seem, in this case, that resistance is not high enough in the pulmonary circulation to prevent a L to R shunt if one was present. Certainly no R to L shunt of any significant degree is present since peripheral oxygen saturation is 93 per cent and no polycythemia is present.

Pulmonary hypertension may be caused by:

1. Mitral stenosis or other causes of left-sided failure which result in pulmonary congestion.
2. Extensive lung disease or disease of the pulmonary arteries which greatly increases resistance in the pulmonary circulation.
3. Congenital cardiac lesions with an arteriovenous shunt, like patent ductus arteriosus, septal defects, anomalous pulmonary venous drainage or aortic-pulmonic fenestration.[1]
4. Primary.

Pulmonary hypertension from the first three causes is obvious but primary pulmonary hypertension is rare and its pathogenesis is unknown. It is caused by increased resistance in the pulmonary circulation existing in the absence of any primary disease of the heart or lung.[2]

The lumen of the small pulmonary arteries is greatly constricted due to intimal thickening. Their appearance is similar to that found during fetal life, with frequent thromboses pro-

ducing severe obstruction in the pulmonary circulation. The larger pulmonary arteries may escape involvement. It is not known whether the vascular damage is primary or secondary to the pressure rise.[3]

Normally the pulmonary circulation operates under a low resistance to blood flow and consequently a low pressure. This low resistance is a result of the large capacity and caliber of the vascular bed [4] and the marked distensibility of the pulmonary vessels.[5] Any elevation of pressure in the pulmonary circuit when primary lung disease is the cause will ultimately produce chronic cor pulmonale.

CHRONIC cor pulmonale is right ventricular hypertrophy resulting from disease primarily involving the lung and pulmonary circuit. It does not include left-sided cardiac lesions or failure or congenital heart disease where an arterio-venous shunt exists; or does it necessarily mean right ventricular failure must be present.

Mack and Snider [8] have divided the causes of chronic cor pulmonale into two categories:

1. Pulmonary diseases associated with chronic diffuse obstructive emphysema and
2. Pulmonary diseases in which the pathologic process is localized in or about the pulmonary vessels.

If emphysema of the obstructive type is present in this case, it is certainly in its infancy and diagnosis is almost impossible at this time. This narrows the possibilities down to type 2 with physiologic findings not pronounced enough to produce evidence of chronic cor pulmonale.

Intraluminal and extraluminal involvement of the pulmonary vessels may be considered to lead to chronic cor pulmonale. Multiple repeated small pulmonary emboli occurring over protracted periods of time, frequently without clinical manifestations eventually lead to a marked reduction in the pulmonary vascular bed. Such pathologic processes are recognized only when lung biopsies are examined pathologically. Fibrous intimal thickening such as found in arteriosclerosis occurs with organization and recanalization. These sclerotic changes are probably secondary to some unknown factor causing increased pulmonary arterial pressure[4] and have been considered as examples of primary pulmonary hypertension. Sickle-cell anemia and Schistosomiasis have also been described as causing chronic cor pulmonale.

Extra luminal processes include such diseases as metastatic carcinoma of the lung, silicosis, acute interstitial lung fibrosis, scleroderma, etc. which cause granulomatous or fibrous proliferation in the interstitial lung tissue.

Intubation of the pulmonary artery by right heart catheterization offers the best method yet for the early detection of pulmonary hypertension. In the vast majority of cases it will also rule out a congenital cardiac defect giving, at the same time, much information on cardiac hemodynamics.

Dexter [9] has demonstrated, in patients with pulmonary arterial hypertension, a normal pulmonary venous capillary pressure. In patients with mitral stenosis or left ventricular failure both the wedge and pulmonary artery pressures are elevated. This differentiates pulmonary hypertension present in such diseases as emphysema from those which involve the left heart.

SUMMARY

FROM this discussion and the physiologic aspects of the case presented, there is certainly no proof that primary pulmonary hypertension exists. Neither is it true that obstructive emphysema is present. There is no basis of fact that there is any pathologic process localized in or about the pulmonary vessels. A congenital cardiac defect has been almost conclusively ruled out.

It seems that there is some left-sided cardiac lesion (possibly a stenotic pulmonary vein or two) as yet unidentifiable, which is causing elevated pressures throughout the whole lesser circuit including the pulmonary arterial wedge pressure. It is also likely that the pathology is not confined to and involving the lung and/or pulmonary circulation. If this is true the patient then will not develop

a chronic cor pulmonale and will probably go into right heart failure.

At any rate, the patient is an interesting candidate for future study, including pulmonary function studies, lung biopsy and left heart catheterization. Definitive etiologic diagnosis must be held in abeyance and for the present a diagnosis of pulmonary hypertension probably secondary to an unmanifested left heart pathologic process seems reasonable.

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Sidelights on Longevity

Impressive strides in increasing the average number of remaining years of life are far reaching:

—If a child under 18 is orphaned today, chances are twice as great that he will lose his father instead of his mother; 2 per cent of the orphans in the United States have lost both parents; 30 per cent have lost their mothers only, and 68 per cent have lost their fathers;

—There are fewer chances today, however, of a child under 18 becoming an orphan. As late as 1920, 16 per cent of our children had lost one or both of their parents due to death. With the marked gains in saving lives in the middle and older ages, this figure has now been reduced to 5 per cent;

—Our widowed population has also declined significantly. In 1900, 9 per cent of the males in the United States who had married had lost their wives and had not remarried. This figure was reduced to 4 per cent in 1954 (adjusting for age). In 1900, 20 per cent of the females who had married were widows as compared to 13 per cent in 1954. Because females have a longer average length of life, they are more likely to be widowed than males;

—Men have also benefited from reduced mortality as shown by an increase in the average length of work-life expectancy. Males born in 1900 had an average work-life expectancy of 32 years. Today this figure has increased to 42 years;

—Gains in average length of life in the United States have steadily increased the proportion of our population in the older ages. In 1900, only 4 per cent of the population was in the age group 65 and over; today that figure is 9 per cent. In 50 years our population over 65 has increased by 11 million.

Although life expectancy for Negroes is still somewhat lower than for whites in the United States, the phenomenal reduction of Negro deaths in early infancy and childhood has greatly narrowed the gap. Significant increases in the average remaining years of life have been made for all ages of the Negro population since 1930; the overall rate of progress for Negroes during the past two decades has been more rapid than that of the white population.

—May (1956) Bulletin of the Health Information Foundation.

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The Modern Treatment of Portal Cirrhosis*

Modern concepts of electrolyte physiology and liver function have radically altered our ideas about cirrhosis. In this well-reasoned and highly practical paper, Dr. Brick spells out the technic of managing portal cirrhosis.

In discussing the management of cirrhosis, it is important to know the stage of the disease with which we are dealing. There is a vast difference between treating a compensated cirrhotic patient and treating a patient in hepatic coma. For this discussion, I divide the cases of portal cirrhosis clinically encountered into compensated and decompensated cirrhosis. The latter category includes patients with jaundice, gastro-intestinal hemorrhage, ascites, and coma. Unfortunately, in many of the decompensated patients with cirrhosis, more than one of the complications is encountered at the same time. In the background of 75 to 80 per cent of all portal cirrhotic patients in America there is alcoholism, usually associated with poor nutrition. In this sense, portal cirrhosis varies from the "post-necrotic" or post-hepatitic cirrhosis which is a less common entity in clinical practice. Once a patient has cirrhosis, alcohol in any of its forms, varying from beer and wine to whiskey, should be interdicted. Time and time again we have seen patients with cirrhosis improve markedly only to have their improvement punctuated by the complications of cirrhosis induced by alcoholic sprees or constant drinking of whiskey. Many of our problems with cirrhotic patients would cease if we were able to handle more efficiently and more wisely the problem of chronic alcoholism in these patients. Though it would appear that a patient is getting along quite well, time and time again I have seen clinical evidences of deterioration when the patient again starts drinking. The exact way alcohol works on the diseased liver is not known. It appears to me that in the cirrhotic patient the alcohol becomes a severe toxic substance, not unlike carbon tetrachloride in a normal individual. The process is not always related to a lack of food intake. In early or well compensated cirrhosis, the mere abstinence of alcohol will be sufficient to retain compensation or to gain compensation in the mildly damaged liver. You can promise these patients normal longevity (so far as the liver is concerned) if they abstain from alcoholic beverages.

Compensated cirrhosis is often casually picked up in a coincidental physical examination for other illnesses or for routine examinations. The earliest finding may be a palpable liver or spleen or possibly finding spider angiomata in the patient who is having few or no symptoms. Many times, however, careful questioning will uncover fatigability, occasional

*Presented to the Section on Gastroenterology and Proctology, 100th Annual Meeting, The Medical Society of New Jersey, May 16, 1956, Atlantic City. Dr. Brick is Associate Professor of Medicine at Georgetown University School of Medicine

nausea, and anorexia. In these cases a normal nutritious diet with possibly an increase in protein will be sufficient, if the patient abstains from whiskey. With big livers, a liver biopsy may sometimes reveal fatty infiltration. Although lipotropic substances in dosages of 5 Grams daily, such as methionine or choline, may be helpful in aiding a more rapid turnover of the fat in the liver, these substances should not be used for more than 30 to 45 days. Any benefit to be obtained from them will be evident by that time. In most cases of fatty infiltration, an adequate diet with 70 to 100 Grams of protein and adequate calories will be sufficient to guarantee against any complications of fatty infiltration. In practice, with an adequate diet, I do not see the necessity for supplemental vitamins.

THE decompensated patient will show gross evidences of this at physical examination. Jaundice usually indicates a necrotic phase of cirrhosis. It may (or may not) be accompanied by other complications such as ascites and edema or gastro-intestinal hemorrhage. In the patient who has jaundice alone as evidence of his decompensation, absolute bed rest (until the jaundice has subsided) is a necessity. In this patient, an adequate diet with 70 to 120 Grams of protein daily and adequate rest may be sufficient. Only by hospitalizing the patient, can you be sure that alcohol is not being obtained. Rapidly deepening jaundice may indicate either overwhelming necrosis or a hepatoma superimposed upon the cirrhosis. In the average case of cirrhosis in which jaundice is the only complication, there will usually be a satisfactory subsidence of the serum bilirubin with treatment. We have recently been using the metisteroids, prednisone and prednisolone, in cases in which there is necrosis as evidenced by jaundice. Use of these steroid substances is not fraught with the dangers of sodium retention and potassium loss as is true of the older steroids. Furthermore, there appears to be some anti-necrogenic effect of the steroids in liver disease with necrosis. In some of our cases we have already experienced satisfactory responses with metisteroid therapy.

The ascitic cirrhotic always presents a grave problem. This complication is a chronic disease which is going to take a long time to treat. We try at all costs to avoid paracentesis of the abdominal fluid because removal of this fluid also removes valuable substances in the form of albumin and also electrolytes, particularly sodium, chloride and potassium. The indication for paracentesis in these patients is either respiratory embarrassment (in which case x-ray of the chest will indicate markedly elevated diaphragms) or great discomfort. When these indications are present I do paracentesis very slowly and do not try to tap the patient "dry." Rather, I remove about half of the fluid present in the peritoneal cavity, hoping that other measures will effect removal of the remaining fluid. In these patients the best way to follow the accumulation of fluid is by having the patient weighed daily on the same scale. During the early stages of treatment, bed rest is advised. After a paracentesis, there sometimes is a diuresis, probably due to increased renal blood flow after relief of the pressure of the fluid in the abdominal cavity. If renal function is adequate (as measured by urinalysis and a blood urea nitrogen) use mercurial diuretics to determine whether diuresis can be obtained. In some cases of portal cirrhosis, mercurial diuretics given two to three times weekly may be valuable. In other cases, however, very little help can be obtained. However, a test of two to three weeks with mercurial diuretics is advisable when kidney function is within normal limits as it is in most cases. After this period, if no perceptible diuresis has been obtained, there is little point in continuing the mercurials. Patients with ascites need a salt-restricted diet with no more than 100 to 150 milligrams of sodium daily. The use of salt substitutes is advisable. I have not been impressed by the use of acetazolamide (Diamox®) in patients with ascites due to cirrhosis. There are some dangers in the use of this drug in liver disease. The diuretic response in my experience has not been nearly as good as in the cases of congestive heart failure that have been reported. Ammonium chloride, one to two Grams three to four times a day until recently has been practically stand-

ard therapy. However, in some cases of ascites due to cirrhosis, these nitrogenous-containing products may cause hepatic encephalopathy or a condition verging on the precomatose neurologic state of hepatic insufficiency. In my opinion, ammonium chloride may be given cautiously and the patient observed. Many patients with ascites tolerate moderate doses of ammonium chloride without any difficulty. A low salt, nutritious diet with a moderate amount of protein, about 60 to 70 Grams daily, is advocated. Fat in the diet, as in all of the diets for cirrhotics, may be used as tolerated. There is no evidence that a moderate amount of fat is harmful to the cirrhotic liver. Schiff and his associates demonstrated that high fat diets may cause improvement in patients with fatty livers. This has been demonstrated by liver biopsy. The patient's morale must be continually kept high in cirrhosis with ascites. It must be explained that this is a complicated manifestation of his disease which may take a very long time to relieve. Persistence in treatment is a necessity. Recently, taking advantage of the diuretic action of the metisteroids, I have used these preparations in ascites due to cirrhosis. In some cases in which prednisone and prednisolone have been used, there has been an almost immediate diuresis which is followed by a slower loss in ascitic fluid. Metisteroids in this instance are an adjunct to the other treatment which has been mentioned. As all of us know, we occasionally encounter recurrent and persistent ascites despite the treatment above described. Surgical procedures for ascites have not, by and large, been very successful. No one advocates portacaval shunt for ascites. It has been noticed, incidentally, in patients who have had shunts for varices and who have had ascites, that occasionally there is improvement in the ascites. However, this may be due to the general improvement that occasionally occurs when hemorrhage has been stopped on a more than temporary basis. In a small group of patients, I have noted that splenectomy, usually done for hypersplenism (in which cases there has been associated ascites) improvement has occurred to a dramatic degree after splenectomy. We are still studying this aspect of treatment for ascites and feel that splenectomy is indicated in a very limited group of cirrhotic patients. The limitations will have to be defined more accurately by future investigation.

THE most trying cirrhotic patients are those with upper gastrointestinal hemorrhage, usually from esophageal varices, although occasionally from peptic ulcer of the duodenum. Peptic ulcer appears to be a more frequent disease in the cirrhotic than in the non-cirrhotic patient. Another form of gastrointestinal hemorrhage occurs from hemorrhagic gastritis which is also more frequently found in patients with portal hypertension than otherwise. However, massive hemorrhage is a real calamity for the patient with cirrhosis. A patient who otherwise was well compensated, as far as the cirrhotic process was concerned, may be thrown into fatal hepatic insufficiency by gastrointestinal hemorrhage, even though the hemorrhage may be stopped. The severity of this complication of gastrointestinal hemorrhage is reflected by mortality rates of 50 to 70 per cent in the first hemorrhage in patients with cirrhosis and esophageal varices. Not infrequently, also, the additional complications of jaundice and ascites either together or singly are encountered in the bleeding patient. This but means that the situation is more desperate. One of the most common factors in the development of hepatic coma is gastrointestinal hemorrhage. Any prognostic forecast in gastrointestinal hemorrhage must take into consideration the patients dying in coma, whose state has been contributed to by the hemorrhage. I have shown by routine esophagoscopy of all cirrhotics that esophageal varices occur in 60 per cent of these cirrhotics whether or not there have been bleeding episodes. Should prophylactic shunt therapy be done in patients with varices and cirrhosis who have not had an episode of hemorrhage? My own series is small and I am not prepared to insist on such a procedure in all such patients. However, I do feel that when the varices are large and extensive, such prophylactic major surgery is indicated. In the bleeding patient, the routine use of the Blakemore-Sengstaken tube is helpful. When adequately placed, and inflated, with sufficient traction, this pneumatic tamponade

will stop bleeding from varices in the esophagus. However, pneumatic tamponade has its own inherent problems and cannot be used safely for more than 72 hours. I have seen erosive esophagitis and ulcerations of varices after a longer period of use of these penumatic tamponade instruments, particularly when pressure in the form of inflation and traction has been used to stop the bleeding. If bleeding continues for more than 72 hours after the tamponade has been released, the situation is indeed a grave one. During the bleeding episode the standard therapy for blood loss is adequate blood replacement. This should be carried on by following the hematocrit every eight hours. Try to have the hematocrit at a level of 35 volumes per cent or more. With the pneumatic tamponade instrument in place, you can ascertain whether new bleeding has started by periodic aspirations of the stomach. Many patients who have gastrointestinal bleeding, (even without the development of jaundice indicating necrosis) will rapidly pass into the precomatose and then the comatose stage of hepatic insufficiency. One of the factors may be the anoxia to the liver caused by the rapid blood loss. Another factor may be the rapid increase of nitrogenous products into the systemic circulation because of the large amount of blood in the gastrointestinal tract which, in its breakdown, dumps nitrogenous products into the general systemic circulation. It is therefore necessary, in bleeding into the gastrointestinal tract, to keep the tract as empty as possible of such blood. Daily, or even more frequent, enemas are advised. Cathartics in small doses such as sodium phosphate or magnesium sulfate may be indicated. This is one contribution to hepatic coma that may be due to emptying of the blood from the gastrointestinal tract. When bleeding has ceased and the pneumatic tamponade instrument can be removed, a soft nutritious diet is started. Use antacids such as aluminum hydroxide preparations to try to eliminate the peptic erosive factor in the lower esophagus. If there are no other complications, and the bleeding has stopped, the patient should be prepared for portacaval shunt or splenorenal shunt surgery. Once bleeding has occurred in a patient with esophageal varices, a shunting procedure should be done. Results of these procedures have now been under evaluation for ten years and, in terms of cessation of bleeding, they have been found successful.

IN THE worst phase of hepatic failure there may be findings or combinations of findings such as jaundice, ascites, hemorrhage, fetor hepaticus, and hepatic encephalopathy. Extrahepatic manifestions as a result of hepatic failure are noted and usually indicate a terminal phase of liver failure. Central nervous system symptoms such as apathy, somnolence, drowsiness, disorientation, delirium, and convulsions usually terminating in coma are variably found. Nitrogen retention, oliguria, or anuria reflect renal failure. Pulmonary edema or circulatory collapse indicate cardiovascular failure. High temperatures, usually terminal, point to the loss of control of vital regulating mechanisms. Not all of these extra-hepatic effects are seen in each case, but usually some features are present. The diversification of the clinical pattern (as above outlined) indicates that no single factor can be held responsible. No single biochemical abnormality or combination of such abnormalities can explain liver failure. The central nervous system symptoms mentioned, if unchecked, usually eventuate in coma. Hepatic coma is a grave prognostic sign though not invariably fatal. When temporarily aroused from coma, patients often sink back into it. In liver disease, the important precipitating factors of hepatic coma are: infection, hemorrhage from esophageal varices, and injudicious use of drugs, particularly morphine. *Morphine should never be given to cirrhotics.* Physical examination and laboratory findings in hepatic coma are not distinctive nor do they differ greatly from the precoma findings.

In recent years, attention has been directed to the relationship of protein intake to some of the nervous system symptoms and signs. It has been found that a high protein diet, ammonium chloride, ammonium-containing exchange resins and methionine will promote a state in some patients with advanced liver disease resembling the spontaneous precomatose condition of liver disease. This state consists of extreme apathy and confusion, increased

salivation, slow slurred speech, nocturnal ramblings, bowel and bladder incontinence, hyperreflexia, tremors of the extremities and tongue, eventuating in a flapping tremor of the outstretched arms characterized by rapid flexion-extension movements at the metacarpophalangeal and wrist joints. Electroencephalograms show bilaterally synchronous slow waves in the delta range superimposed on a normal record. This state was found to be reversible when the inciting factor was removed and indicates in the spontaneous cases the necessity for restriction of protein intake. Blood ammonia has generally been found to be elevated. This apparently is due to failure of the liver to metabolize ammonia reaching it from the portal blood or by diversion of portal venous blood in the collateral channels. The latter pathway would be enhanced by portacaval anastomosis. We will have to be observant in the future to ascertain if neurologic and mental changes are more common in this group. It may be necessary to restrict dietary protein in the group with shunting procedures. However, not all observers have found absolute correlation of elevated ammonia levels either with the precomatose or comatose state in chronic liver disease. The prognosis of hepatic coma is very poor since it signifies liver death. A suggested daily routine for hepatic coma would include the following:

1. Two liters of 5 per cent glucose in distilled water to which is added 100 cubic centimeters of 50 per cent glucose, an ampule of Vitamin B complex and 72 milligrams Vitamin K, given intravenously.

2. Stomach tube feeding of 1200 to 1800 calories containing 30 to 40 Grams of protein.

3. Aureomycin® or Neomycin® 500 milligrams intravenously in the glucose solution twice daily.

4. Glutamic acid in divided dosage by stomach tube or as sodium glutamate intravenously to a total of 25 Grams daily.

5. Human salt-free serum albumin as required.

6. Electrolytes as required with a special reference to sodium, potassium, and chloride as determined by daily electrolyte determinations.

7. Transfusions of whole blood for anemia or bleeding.

In liver failure antibiotic therapy has appeared to be helpful, probably because of a change in the bacterial flora of the gastrointestinal tract. Because of elevated blood ammonia levels it has been suggested that the coma is due to an intracellular disturbance of ammonia metabolism. The normal ammonia binding mechanisms of the brain cell (the combination of glutamic acid with ammonia to form glutamine) was postulated to be ineffective. Therefore, glutamic acid would, it is suggested, "tie up" the excessive blood ammonia by combining with it to form harmless glutamine. There have been divergent opinions as to its efficacy. In my hands it has not been outstanding. However, since it apparently is not harmful to the patient and occasionally has seemed to arouse the patient from his unconscious state, it is worthy of trial.

For sedation, morphine should never be used. I use only long acting barbiturates and chloral hydrate for restlessness. With persistence and careful attention to details and to nursing care, some patients in deep hepatic coma for over a week may respond and survive. Seeing such patients, even if only a few of the many patients dying in hepatic coma, is encouraging and keeps physicians persisting in therapy despite the apparent hopelessness of the situation.

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Dr. Bleiberg's Hydrocortisone Paper

In the article beginning on page 371 of the July JOURNAL, Dr. Bleiberg's work was erroneously attributed to the Newark Presbyterian Hospital. This is an error which THE JOURNAL regrets. The work was done at the Newark Beth Israel Hospital on Dr. Bleiberg's patients. THE JOURNAL publishes this correction in fairness to Dr. Bleiberg and to the two hospitals concerned.

Historical Article • • •

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Asbury Park

The Historical Development of Cardiac Surgery

II. Era of Experimental Beginnings

In the June 1955 issue of this JOURNAL Dr. Henderson presented a brief history of cardiac surgery in the pre-scientific era. He now continues the story into the era of its experimental beginnings.

THE earliest known experiments concerning the heart were performed on the valves of dead specimens.[1] These are found in the Hippocratic treatises of the fourth century B.C. Nothing more than crude anatomic descriptions resulted from these animal dissections. Actually, an enormous amount of anatomic dissection had been done before the time of Aristotle (384-323 B.C.). Although his accomplishments in animal dissection and encyclopedic works earn him the title "Founder of Comparative Anatomy," his erroneous interpretations were one of the prime causes of the extraordinary tardiness of the discovery of the circulation.[2]

Many ancient physicians did animal experiments. Herophilos, Erasistratos, Marinos, Rufus of Ephisus and Galen are notable among them. Until the 16th century, almost all vivisection and experimental efforts were designed to confirm ancient beliefs rather than to challenge or correct them.

Prior to William Harvey (1578-1657), many observations concerning the cardiovascular system had been made successively. The problem was to unite these pieces of diverse information into one whole comprehensive mechanism and to exclude the tenacious misinformation of the past. Harvey was the first who clearly and completely comprehended this whole. Because of this and because of his truly scientific approach in its solution, rightfully does he deserve to be called the Father of Modern Experimental Medicine. William Harvey's *Exercitatio Anatomica de Motu Cordis et Sanguinis in Animalicus* of 1628 formed the germinal center from which all quantitative experimental medicine, in its modern sense, unfolded and matured.

This gift to the world on his fiftieth birthday set the stage for the outburst of original experimental work which quickly followed. Probably nothing in the long history of science is more astonishing than the immediate effects of this dispassionately published work. The consecrated breath of discovery began to animate all minds. Jean Riolan (1577-1657), the greatest anatomist of his time, declared: "Everybody is discovering something new nowadays."[3]

It was left for countless others to develop successively the anatomic, pathologic and physio-

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logic groundwork necessary as a preliminary to experimental and operative surgery of the heart. Within fifty years after the death of Harvey, this groundwork was reasonably secured. The ancient mysticism which surrounded the heart and which had been engraved upon the minds of men since the dim past was finally dispersed. The heart was no longer the seat of the soul, the emotions, the vital spirits; it was, by the end of the 17th century, more simply a muscular pump to circulate blood.

Brief mention can be made here of only a few of those whose labors relegated this organ to the viscera and into the hands of the surgeons, leaving the sovereign and sensual heart to the poets. More than a few of those involved are unforgettable names in scientific history; many more are embalmed in the biographical dictionaries. Still more have become lost or have become as meaningless as the genealogy of David in the Book of Chronicles.

THE SEVENTEENTH CENTURY

THE 17th century was ushered in with an accelerating growth of knowledge about circulation. Marcello Malpighi (1628-1694) of Pisa and Messina had proved the existence of the capillary circulation and the bronchovascular nature of the lungs. Richard Lower (1631-1691) of Cornwall astonished the scientific world with the same experiments Vesalius had performed for amusement one hundred years earlier. Lower demonstrated the arterializing function of the lungs in dogs. This demonstration took place 120 years before Laviosier and deLa Place reported that oxygen in the air was responsible for this function of respiration. Jan Swammerdam (1637-1680), the Dutch physiologist introduced primitive plethysmographic methods of recording heart and lung movements. Pierre Chirrac (1650-1732) reported the first experimental investigations on the coronary vessels in 1698 and demonstrated their importance by ligating the coronary arteries in dogs producing cardiac standstill.

The lymphatic circulation had been discovered, red corpuscles described and many clinicians were beginning to correlate morbid anatomy with clinical data. The turn of the 17th century witnessed wondrous advances in every scientific channel. Gilbert had given the world electricity and magnetism. Galileo and Sanctorius presented civilization with the clinical thermometer. Boyle, Hooke, Malpighi, Lower, Mayow and Borelli began to unravel the mysteries of the ventilating apparatus. The first volume of the Royal Society's *Philosophical Transactions* carried the news of the birth of intravenous medication in the hands of Christopher Wren and Robert Boyle. The infant 18th century began to peep through peculiar optics at a new world heretofore unseen and chemistry became a science.

THE EIGHTEENTH CENTURY

CONTRIBUTIONS from the clinic and the morgue outweighed those from the experimental laboratory. Eagerness spread among clinicians to follow their patients from the bed to the postmortem table. The bare beginnings of bedside teaching afford a contiguous landmark in the shifting interests of the 18th century.

Stephen Hales (1677-1761) carried out the most important hemodynamic studies to date. Using horses, sheep and dogs, he estimated both hydrostatic forces and velocity of flow by cannulating veins and arteries. His are the first direct attempts to measure arterial blood pressure. He investigated the behavior of the pulse with the sphygmoscope.

The greatest physiologist of the century was Albrecht von Haller (1708-1777). Of particular importance was his demonstration of the automatism of cardiac muscle. To review his 13,000 scientific papers is to review many important "forgotten" observations rediscovered in our own times.

Of clinical significance are the therapeutic contributions of De Senac (1693-1770) who introduced quinine for "rebellious palpitations" and Withering (1741-1799) who contributed foxglove (digitalis) for the failing heart. Pathology became a major science under Morgagni, Vieussens, Baille, Abernethy and

others. Edward Jenner (1749-1823), better known for his discovery of vaccination, was the first to correlate angina pectoris with occlusive disease of the coronaries.

THE NINETEENTH CENTURY

THE surge of scientific inventiveness and exposition of fundamental knowledge extended well beyond anything attained in all other centuries combined. The feature that characterizes the latter half of this century, in experimental medicine, was the rapid shift in the motives of the investigators. Men continued to experiment for the sake of new information, but now the sense of application began to penetrate the laboratory. There was a new use for the laboratory now and clinicians drifted in from the wards to duplicate in animals the effects of disease in man and to elaborate and create their surgical armamentarium. The hearts of animals could be explored and operated upon at will with a high degree of success. Only time and courage would be needed to substitute man for animal.

A new literature began to appear. Medical men were publishing their latest surgical technics carried out in the laboratory. Claude Bernard (1813-1878) became the parent of experimental medicine in the 19th century. His experiments became standards for others to imitate.[4] Numerous texts on operative physiology appeared. Notable is one by von E. Cyon (1876),[5] providing ample evidence of the great strides made in experimental intrathoracic surgery. Systematic perfusion experiments had already been performed in 1875 by Merunowicz in Ludwig's laboratory and were, almost simultaneously, carried out in the United States by Austin Flint (1812-1886).[6]

Dominique-Jean Larrey (1766-1842) was surgeon to Napoleon. Stimulated by an unsuccessful attempt to save the life of a man who had stabbed himself in the heart, he was the first to design experiments (in dogs) to demonstrate that penetrating heart wounds were not always fatal.[7] He dissected cadavers and described in detail the transthoracic approach to the pericardium. Bonetus [8] and Morgagni [9] had experimentally shown the effects of large collections of fluid and blood within the pericardial sac. Romero [10] had attempted pericardiotomy drainage. But it was Larrey who first carried out experimental cardiac surgery intentionally to develop procedures adaptable to humans.

Others began to tinker with this divine anatomy. Francois-Franck (1877) [11] distended the pericardial sac with compressed air, Cohnhiem (1899) [12] with oil. Lagrolet (1878) [13] produced traumatic hemorrhage to determine the effects of pressure and mechanism of death in cases of heart wound and rupture. It was concluded that blood loss itself was not as important as mechanical interference with the heart beat by the increased intrapericardial pressure. Rose (1884) [14] coined the word "herztamponade" to describe the situation.

THE earliest operations upon animal heart valves were by clinicians, not surgeons. An ophthalmologist first experimented with the surgical production of valvular heart disease. O. von Becker (1872),[15] interested in the pulsations of the retinal vessels in aortic insufficiency, created this lesion in dogs by tearing one or more aortic cusps with a glass rod which he passed down the carotid artery into the valvular region. Thus, the retinal vascular changes could be observed from the onset of the lesion. Virchow's famed student, Elimar Klebs (1875) [16] conducted similar experiments. He fashioned tiny knives upon a long rod which he called "valvulotom," thus inventing both a new instrument and a new word. He introduced the instrument down either jugular veins or carotid arteries at the base of the animal's neck, creating defective tricuspid or aortic valves and reproducing murmurs and peripheral effects of valvular heart disease.

Julius Cohnheim (1889),[12] produced valvular defects in much the same way. However, his sounds were made of whale bone and metal. Later, he became the first to produce these lesions through an open chest. Cohnheim reproduced the effects of pulmonic stenosis by purse-stringing the base of the pulmonary artery and fashioning a "loop-knot" which could

be tied down at will postoperatively. Using dogs and rabbits, he was not only the first to perform valvular surgery through an open chest, but also became the first to use such technics for routine teaching. His students were able to see first hand the effects of acute valvular lesions upon arterial pressure curves, the production of murmurs, and other clinical phenomena.

Rosenbach (1878),[17] with Klebs' valvulotomes, became (quite by accident) the first to produce experimental bacterial endocarditis when one of his animals succumbed to the infection shortly after surgery.

Cardiac arrest and ventricular fibrillation must certainly have been encountered in many of these experiments. Quite expectedly during this period, we find Moritz Schiff[18] of Frankfort carrying out the first experimental observations on cardiac massage.

A LONG series of experiments, concerned with the production and repair of heart wounds,[19] was initiated by M. H. Bloch of Copenhagen in 1882. A monograph published fourteen years earlier by George Fisher[20] had aroused some hope for the salvage of patients inflicted with heart wounds. Fisher collected reports on 452 cases of various types of heart wounds and showed that about 15 per cent recovered and that most deaths were delayed. The long spell of impotence was thus broken by Fisher[20] in the literature and Bloch[19] in the laboratory. Bloch was bold enough to propose that his experimental work be applicable to human cases.

A sudden burst of enthusiasm seems to have filled the last decade of the 19th century. Papers on experimental traumatic cardiac surgery swelled the medical literature.[21-26] Before 1900, the human had replaced indeed the animal upon the operating table and human traumatic cardiac surgery had become a reality. This fact, together with the vast accumulation of new knowledge concerning the anatomic, pathologic and physiologic aspects of the heart and circulation quite naturally led a few imaginative and unconventional minds to protrude a little into posterity and predict with complete assurance that other forms of heart disease might also fall to the surgeon.

THE TWENTIETH CENTURY

AGAIN it was a medical man who first attempted to develop, for the surgeons, a technic for opening a stenosed valve. In 1902, Sir Thomas Lauder Brunton of St. Bartholomew's Hospital suggested that, since such good results were being reported in the surgical treatment of heart wounds, similar results might be obtained in cases of mitral stenosis.[27,28] He fashioned valvulotomes from ladies' hat pins. He demonstrated on cats' hearts the feasibility with which one could manipulate the mitral valve through the left ventricle. The animadversion heaped upon the elderly gentleman and the anguish he suffered as a result of critical editorials directed at his daring, is a story in itself.

Theodore Fisher condemned Brunton's idea on the basis of finding myocardial fibrosis in a large proportion of postmortem mitral stenotics. He cited the case of a 64-year old man who worked hard up until his death in spite of a finger-sized mitral orifice. Sir James McKinzie gave the proposal careful consideration, but felt inclined to leave the trouble and dangers to others. "I should feel very keenly," answered Brunton, "the disapprobation of my suggestion . . . were it not that it seems to me that it has been written under a certain amount of misapprehension in regard to both my object and experiments . . . Art is long and time is fleeting and in the meanwhile many patients are dying of mitral stenosis." In response to continued mocking, he stated, "I cannot hope from my own experiments alone to prove the advisability of an operation against which . . . so many *a priori* arguments can be brought; and, therefore, hope that others will take up the subject as well as myself."

In spite of the criticism of Brunton's proposal, a new atmosphere permeated the experimental laboratory and brought in the person of a new character in this setting: the experimental surgeon. This new air was the reflection of a new motive: to devise operative pro-

cedures designed to correct acquired cardiac lesions in human beings.

At this time, Alexis Carrel (1873-1941) began his twenty-five year period of experimental cardiac surgery. To survey this Nobel laureate's contributions is to preview cardiovascular and transplantation surgery of the present era. So numerous are these important experiments that only a brief summary can be given here. He perfected the technic of end-to-end vascular anastomosis (before Carrel's time vascular lesions were treated by ligation in continuity).[29] From anastomotic surgery he advanced to segmental replacement by grafts, also demonstrating the feasibility of preservation of vascular grafts by refrigeration.[30] Following this, he did successful experiments in the transplantation of limbs and organs (including the heart and lung) from one animal to another with preservation of blood supply. He was successful in keeping excised viscera alive and functioning *in vitro*.[31] He operated within the lumen of the thoracic aorta without the interruption of the circulation by inserting metallic tubes within the vessel to continue blood flow distally. Distal blood flow was maintained also by anastomotic channels between the left ventricle and descending aorta. Carrel performed digital exploration of the atria and ventricles and resected large portions of the ventricular walls. Numerous valvular operations were devised, some in conjunction with Tuffier.[31] A fair sample of his ingenious efforts is seen in an experiment designed to reduce the effects of mitral insufficiency. Here, a slight stenosis of the upper ventricular chamber was produced by cuneiform resection of the ventricular wall below the annulus. His intracardiac operations were performed in a relatively dry field by temporarily clamping the pedicle of the heart with a non-crushing clamp for two to three minutes.[32] He proposed a vascular graft between the left auricle and ventricle to overcome the effects of mitral stenosis, but stated that incision of the valve was another possibility.[33]

Carrel developed a technic[34] for enlarging the pulmonic valvular orifice in cases of pulmonic stenosis.[35] In 1914, he said he was already convinced that benefit would be obtained by surgical intervention in pure mitral stenosis, certain cases of aortic stenosis and some cases of stenosis of the pulmonic valves.[31]

He demonstrated that both homoplastic and heteroplastic substances could be successfully transplanted to the pulmonary artery and noted that incision or cauterization of the pulmonic valvular leaflets did not produce significant regurgitation. He pointed out that the incised valvular leaflets had no tendency to unite even three years after operation. The earliest operative approach to coronary heart disease was his subclavian-coronary artery anastomosis.

The earliest operations for dealing with intracardiac anomalies, both experimental and practical, were, necessarily, done blindly without the advantage of visualizing the lesion operated upon. One of the earliest to recognize the advisability of developing open heart technics was Ferdinand Sauerbruch (1875-1953). Under the inspiration of von Mickulitz, Sauerbruch had already achieved fame by exhibiting at the Berlin Surgical Congress in 1904 a technic for operating within a negative pressure chamber designed to maintain some degree of lung expansion during open chest surgery. Thus, one of the important barriers to intrathoracic surgery, artificial ventilation, was to a large extent overcome. In 1907, Sauerbruch conducted experiments to determine the length of time the circulation could be clamped off in order to operate within a bloodless field with the heart opened.[36] By clamping the pedicle of the heart, he found that the animal would survive routinely for about one minute; temporarily tying the vena cavae prolonged the survival time.[37] Similar results were obtained a year later by Laewen.[38]

Among the eminent men who taught and fought during the formative years of Johns Hopkins was William George MacCallum (1874-1944). This pathologist did much to promote the experimental method in his la-

boratory classes.[39] Didactic lectures were kept at a minimum and the students were brought to the animal laboratory for first hand glimpses of the new science of pathologic physiology. For teaching purposes, stenotic valvular lesions were reproduced in dogs by purse-stringing or partly clamping a particular valvular region of the heart, in much the way Cohnheim had done. Valvular insufficiency was produced by tearing the leaflets by the method of Rosenbach. Effects of tamponade were obtained by filling and distending the pericardial sac with fluid under pressure. Pulse wave recordings were made to demonstrate the immediate effects of these artificially induced disease states and the evolution of associated clinical phenomena was observed. With W. S. Thayer, MacCallum studied the transmission of murmurs resulting from artificially created valvular defects and invented a special long-bell stethescope for this purpose.[40]

In this same little laboratory, "The Old Hunterian" (Figure 1), many young physicians experimented. Many of these were destined to become surgeons of great fame. Halsted, Cushing, Homans, Gilman, Dandy and Bancroft were among them. Harvey Cushing was one of the first surgeons to create deliberately valvular heart disease experimentally for the purpose of creating corrective operative technics.[41] Cushing's close association with MacCallum at Hopkins and his personal acquaintance with Carrel and Cohnheim probably initiated his interest and enthusiasm for cardiac surgery. His experimental cardiac surgery came to an abrupt halt by travels abroad, his transplantation to Boston, and an increased interest in neurosurgery. In the Hunterian Shack, Cushing's work was continued by B. M. Bernheim.[42] Bernheim believed that Brunton's question, "Can a mitral stenosis be transformed by surgical measures to an insufficiency with benefit to the patient?" would be answered in the positive with technical feasibility.

World War I compelled a transient lull in this research but by this time there was no doubt that it would be simply a matter of time until some courageous surgeon would make the first attempt to operate upon human valvular heart disease. In 1908, Cushing said: "The mitral valve may become the gateway to the last great Northwest of surgery."[41] Rudolph Matas stated a year later: "Though the surgeon may not be able to profit immediately by these brilliant laboratory accomplishments in cardiovascular surgery, they have for him at least a two-fold interest; namely, they show that with proper methods of hemostasis and comparatively simple technics successful intracardiac surgery (in the auriculo-ventricular chambers) is possible; and that the possibility of correcting valvular defects of pathologic origin, such as mitral stenosis or insufficiency, as suggested a long time ago by Lauder Brunton, is not such a chimera as many have supposed."[43]

For the next twenty years the literature is clustered with reports on methods, mostly wasted efforts, of reproducing valvular stenosis. It was argued that this was a necessary prerequisite for the ultimate development of a safe and sure operative corrective technic. Rudolph von Haeker (1907) produced stenotic effect by excising a portion of the subannular myocardium and sewing the defect together. He reproduced mitral insufficiency by suturing the lateral leaflet against the inner wall of the ventricle. Apparently, he was the first to produce a septal defect. By compressing the vena cavae he created a "dry heart" which he then opened and incised the interventricular septum.

Schepelmann (1912)[45] repeated previous experimental work and made an improved valvulotome with which he created regurgitant mitral leaflets by severing chordae tendinae (Figure 2). He joined the auricular appendages of rabbits' hearts in order to relieve the effects of tricuspid stenosis, hoping to send the blood back into the right heart and pulmonary circulation by way of an artificially created interventricular defect. At least this was a new idea.

In 1912, Rhea and Walker peered through the first cardioscope.[4] This first instrument of its kind had a built-in knife so that simultaneous inspection and division of mitral stenosis could be carried out. Since none of their ex-

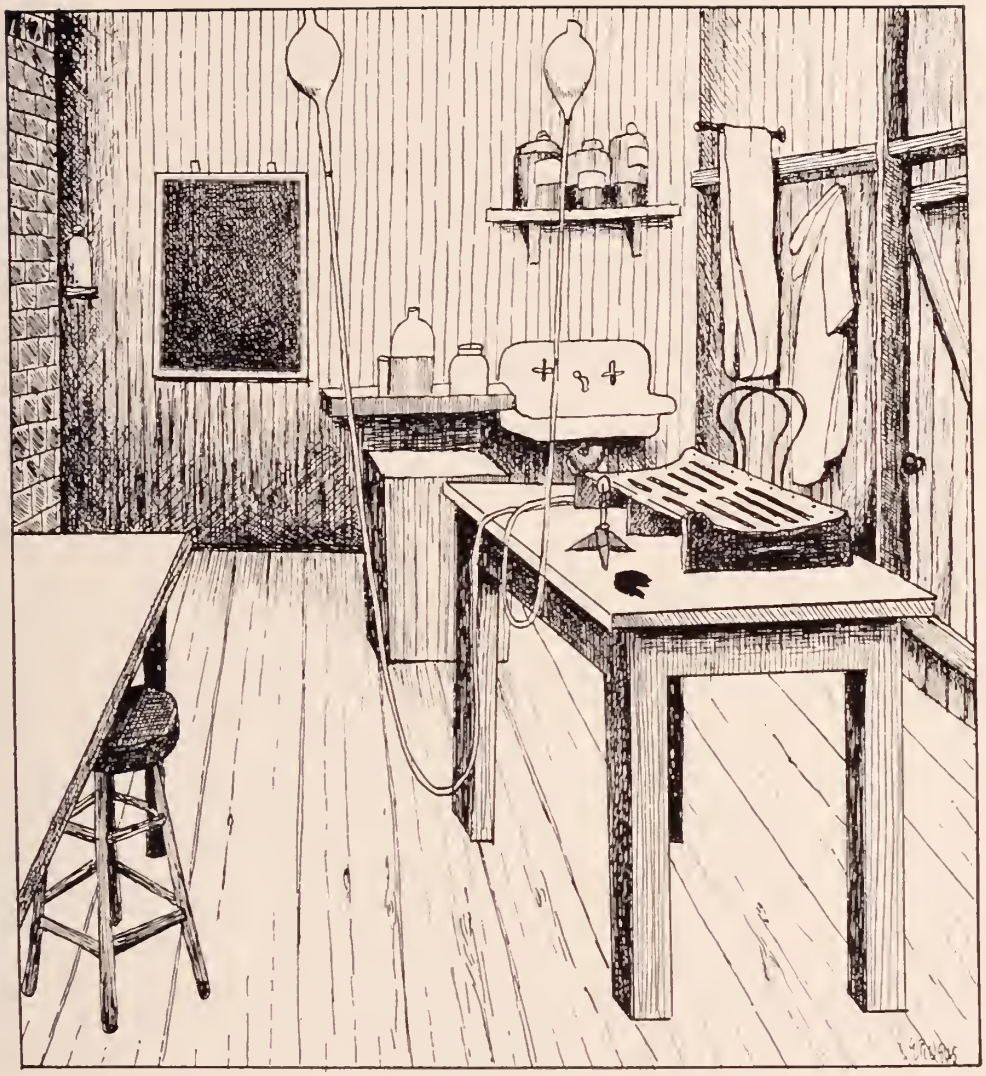


Figure 1. "The Old Hunterian" laboratory ("The Shed") at Johns Hopkins, in 1906. In this small room, Harvey Cushing performed the first experimental cardiac surgery in this country for the purpose of ultimately treating surgically human cases of valvular heart disease.

perimental animals survived, they did not report the invention. Ten years later Elliot Cutler inherited this scope at Harvard and confirmed its uselessness on the basis of inefficient optics. An improved cardioscope was developed by Allen and Graham in 1922.[17] They used this improved scope experimentally to inspect all four valves.

In 1913, the first book appeared which was devoted entirely to surgery of the cardiovascular system.[18] Only 33 of 331 pages are concerned with cardiac surgery. The remainder details technics of vascular suture, surgical measures of aneurysm, vascular and organ transplantation and miscellaneous vascular problems. Jeger has simply described the work of others in the past and mentions only one animal experiment of his own. He advocates shunt operations for aortic and mitral stenosis in much the same manner as did Carrel before him (Figure 2).

Additional attempts to create valvular sten-

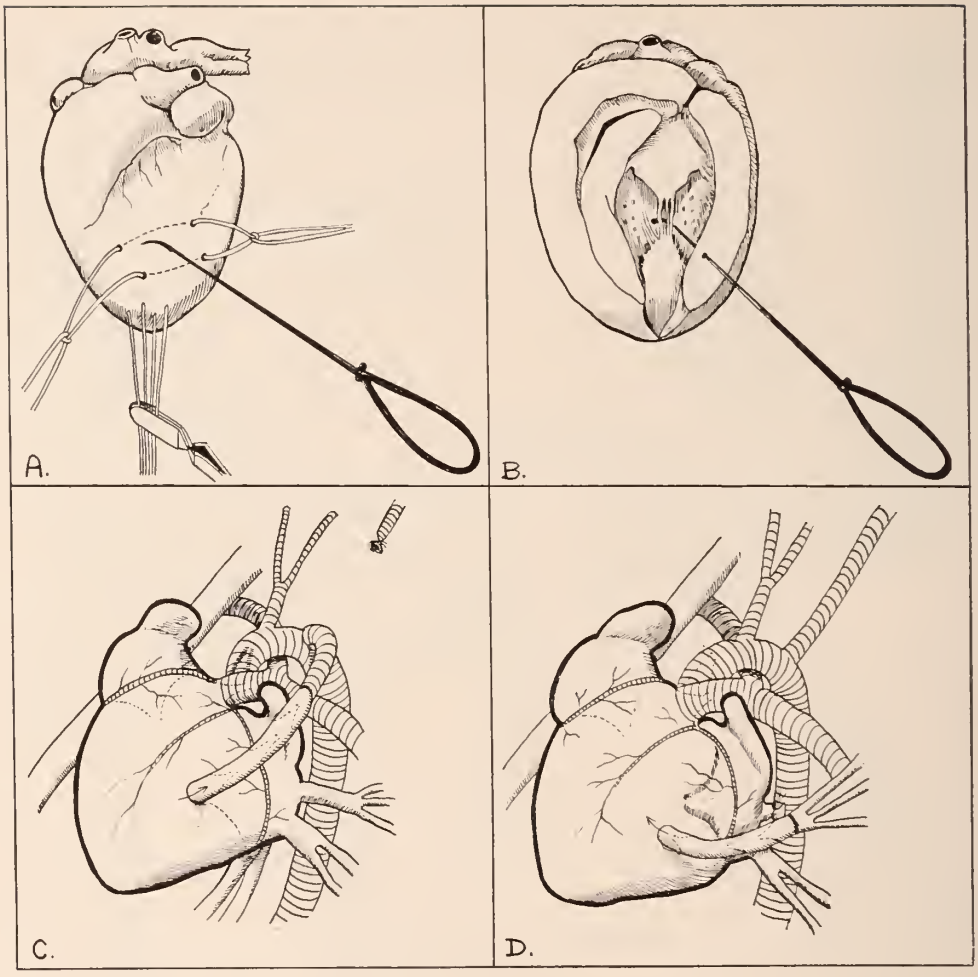


Figure 2. a.-b. Schepelmann's technic of dividing valvular chordae to produce experimental mitral insufficiency (1912).

c. Jeger's proposed operation for circumventing aortic stenosis.

d. Jeger's pulmonary venous-left ventricular shunt proposed for the relief of mitral stenosis (1913).

osis were made by Coryllos (1923)[49] who applied strong doses of radium directly upon the A-V leaflets. Kinsella and Hayes (1927)[50] first injured the leaflets of the aortic and mitral valves using a steel rod and then, after a sixty day interval, injected intravenously nonhemolytic streptococci. This produced vegetative reaction at the site of the injury.

The earliest attempts to perform human valvular heart surgery by Tuffier (1912), Doyen (1913), Cutler (1924), Graham (1924) and Souttar (1925) resulted in only one real success in eleven cases. This discouraging attempt to apply a measure of laboratory success in the operating room served to dampen experimental enthusiasm during the late 20's and for the next fifteen years. Sporadic papers appeared dealing with occasional attempts to reproduce valvular lesions, collateral studies on pulmonary pathologic changes associated with stenotic heart disease, and a number of indirect approaches were suggested for the relief of left atrial or pulmonary arterial pressures in mitral valvular lesions by the creation of septal defects.[51-56] A few sparks appeared during this dark intermission. Gordon Murray (1938)

of Toronto reported his experimental valvular surgery,[57] Robert Gross (1939) of Boston for the first time, successfully ligated a patent ductus arteriosus,[57] and Craaford of Stockholm (1944) excised a coarctation of the aorta.[58]

The Second World War served to stifle experimental cardiac surgery further, but at the same time heightened enthusiasm for human heart surgery in the experiences of surgeons performing traumatic thoracic surgery. Before 1946 no human cases of valvular heart disease had been operated upon since 1928, but the second great wave of enthusiasm for cardiac surgery, born in the minds and hands of Taussig, Blalock, Smithy, Brock, Bailey, Harken and others, after World War II, fulfilled the wishes of Elliot Cutler in 1929: "It is our conclusion that the mortality figures alone should not deter further investigation, both clinical and experimental, since they are to be expected in the opening up of any new field of surgical endeavor."[59]

321 Sunset Avenue

A bibliographic listing of 59 citations appears in the author's reprints.

Hidden Needle Fools the Kids—Or Does It?

A new automatic device that minimizes the pain and fear associated with injections has been developed. It conceals the needle which is automatically triggered when the circular rubber foot is pressed against the skin.

Small, light and easy to use, it is designed only for subcutaneous and intramuscular injections. It can be used with Luer-Lok syringes only. Diabetics cannot use it because the new device cannot accommodate the standard insulin syringe.

In addition to the concealed needle, two other special features are designed to minimize pain and apprehension. They are: a speed of needle penetration three times faster than that by manual technic and "pressure anesthesia" when the rubber foot is pressed against the skin and masks the point of needle stimulus.

The new device will be "especially desirable" for giving injections to children as they will not be able to see the needle at all, according to Frank H. J. Figge, of the Department of Anatomy, University of Maryland Medical School, and Vernon M. Gelhaus M.D. of the Bon Secours Hospital. They report on a study of the injector in the Journal of the American Medical Association 160:1303 (1956).

The very sight of a syringe and needle leads many patients to receive "an exaggerated impression" of the pain actually produced, according to Figge and Gelhaus.

"Since hypodermic needles are often used on very young persons, they leave impressions on the minds of developing infants and children that are sometimes never erased. It is probable that doctor-patient relationships are profoundly and adversely influenced by these early painful injection experiences."

Vacancies for Physicians

General practitioners are acceptable for several vacanices on the psychiatric and neurologic staff of V.A Hospital, East Orange. Waiver of age limit will be considered. GPs will be trained for the work. Salary depends largely on experience and qualification. Communicate with Chief of Professional Services, V.A Hospital, East Orange, N. J.

Announcements • • •

Cancer Information Program

Under auspices of the American Cancer Society, New Jersey Division, a professional information program for doctors has been set up with the approval of The Medical Society of New Jersey and the New Jersey Hospital Association. Visits will be made to New Jersey hospitals on dates set by the administrator and chief of staff. A list of films will be submitted. Staff members will select the films to be shown at their institution.

A representative of the American Cancer Society will be on hand at each program to answer non-medical questions and to indicate what services are available for the physician and the cancer patient.

Known as *MD-Cancer*, the program will be conducted on an informal basis. Its purpose is to bring to the doctor at his convenience in the hospital a program of life-saving import in the vast problem of cancer. For more information write the American Cancer Society, New Jersey Division, Inc., 9 Clinton Street, Newark 2, N. J.

Free Course in Occupational Medicine

Columbia University announces a course in Occupational Medicine Saturdays, 9 to 10 a.m. starting on September 22, 1956. Classes will be held in Amphitheater A, College of Physicians and Surgeons, 630 West 168 Street, New York City.

There will be no formal registration and no tuition fee. The schedule is as follows:

1956

September 22—Scope and Practice of Occupational Medicine
September 29—Industrial Toxicology — General Principles
October 6—Toxic Metals I
October 13—Toxic Metals II
October 20—Toxic Solvents I
October 27—Toxic Solvents II
November 3—Toxic Dusts
November 10—Toxic Gases
November 17—Ventilation, lighting and noise
November 24—Radiation hazards

New N. J. Chest Physicians

Announcement is made by the American College of Chest Physicians that 250 physicians were awarded Fellowship certificates at the June 9 (1956) Convocation. This included six from New Jersey: Burton Cohen, Elizabeth; Robert Henderson, Flemington; Walter Modarelli, Union City; Albert Peckman, Jersey City; Vincent Strack, Newark; and Lawrence Wilson, Absecon.

Our Physicians' Placement Service

Do you know of a young physician looking for a good placement, an assistantship, a clinic appointment or a favorable site for private practice?

Do you know of a doctor of any age who is contemplating a move, entry into a specialty or return from military service?

Do you know of a community that needs a doctor?

The place to clear these requests is the Physicians Placement Service of The Medical Society of New Jersey. Write to that Service at 315 West State Street, Trenton 8, N. J. Do it now!

New Aphasia Association

For the first time in history, there has been established a world-wide confraternity for the dissemination of knowledge about aphasia. Named the International Research Council, the new society will issue a regular monthly publication. The general director of the Association, Dr. Hamilton Cameron, is the designer of the well-known "hand talking chart" which has proved such a practical aid to aphasics. For a free copy of the chart or for further information about the Association, write to Dr. Hamilton Cameron at 601 West 110 street, New York (25) N. Y.

County Society Reports • • •

Bergen

An effort to improve relationships between Bergen County professional organizations was one of the features of the June meeting of the *Bergen County Medical Society*, held at Petrullo's Everglades Restaurant in Hackensack. In addition to the installation of the new administration of the Society, representatives of the County Bar Association, Dental Society and Pharmaceutical Association and representatives of the county hospitals' staffs were invited guests.

Present at the meeting were Dr. Bernard Greenberg, President of Bergen County Dental Society; Mr. Russell Mannino, President of Bergen County Pharmaceutical Association; Mr. David Gelber, chairman of committee on Inter-Professional Relationships of the County Bar Association; Mr. Harold Bernshock, Assistant Administrator of Hackensack Hospital; Mr. Frank J. Schwermin, Assistant Administrator of Englewood Hospital; Judge Francis V. D. Lloyd of Morrison, Lloyd and Griggs, Medical Society Counsel.

The new officers of the Society are Dr. William T. Knight of Oradell, president; Dr. Leo P. Fitzpatrick of West Englewood, 1st vice president; Dr. George Heller of Englewood, 2nd vice president; Dr. Frederick C. Muller of Carlstadt, treasurer; Dr. Charles P. Campbell of Hackensack, secretary and reporter; Dr. John P. O'Connor of Teaneck, assistant treasurer.

Dr. Charles P. Campbell was master of ceremonies. He introduced Dr. William L. Vroom of Ridgewood, the senior member present.

Elected to membership were—to Associate: Drs. Carol Shaw Hamilton, Tor Richter, June R. Flory, Waldo Greenspan, Herman Grossman, E. William Jewell, Dante Liberti, Robert L. Nutt and William G. Soule. To Regular from Associate: Drs. Adolph B. Clachko, Robert A. Gerber, Calogero W. Macaluso, Elmer Pader and Joseph A. Vasselli. To Regular by transfer: Drs. James W. Correll, Edward M. Miller and Frank Spiaggia.

CHARLES P. CAMPBELL, M.D.
Reporter

Cumberland

The *Cumberland County Medical Society* held its June meeting at the Onized Cabin, Palatine Lake, as guests of the Owens-Illinois Glass Company.

A delightful barbecued steak and lobster dinner, prepared and served out of doors, was a most attractive feature.

There was no formal scientific program, but whether due to the stimulation of the ozone, or the odor of barbecuing steaks, there was much informal scientific discussion, with an unusual number of members taking part.

Dr. Frank J. T. Aitken, county chairman of *Economics, Contract Practice and Insurance*, spoke learnedly on the corporate practice of medicine.

Dr. M. David Baxter, chairman of the *County Compensation Committee*, explained, handicapped as he was by cooking odors, Hudson County's resolution at the 190th Annual Meeting.

Dr. Miles E. Drake, county chairman of *Poliomyelitis Control*, spoke of the present status of Salk vaccine and immunization. This was amplified by Dr. Carl N. Ware, county chairman of *Child and School Health*.

Dr. Richard Kerdasha, county chairman of *Cancer Control*, gave helpful information about the American Cancer Society and what it is prepared to do for us and our cancer patients.

The passing from our midst of an emeritus and honored member, Dr. Hugh W. Baker, was noted regretfully. Dr. Baker was a long-time and beloved colleague.

Dr. Marvin W. Solomon, county chairman of *Laboratory Medicine*, spoke on serologic tests for malignancy and how to procure them.

Dr. Mary Bacon read a telegram from Dr. Albert B. Kump, who was at the American Medical Association House of Delegates session. This reported that Dr. David Allman had been unanimously elected President-elect of the American Medical Association. This announcement really climaxed a gala event!

And through all this Cumberland County's new President, Dr. Sherman Garrison, Jr. presided.

LEONARD G. SCOTT, M.D.
Reporter

Hudson

The annual meeting of *Hudson County Medical Society*, terminating the administrative year of 1955-1956, was held at Jersey City Medical Center, on May. 1. Dr. Sigmund C. Braunstein presided.

Elected to active membership were Dr. Edward B. Blum and Dr. Joseph Lubchak of Jersey City and Dr. Arnold Byer of West New York.

As a representative of the New Jersey Pharmaceutical Association, Mr. Raymond R. Ricciardi, a Jersey City pharmacist, requested Hudson County Medical Society to disapprove Senate Bill 57—and endorse a substitute proposal sponsored by the New Jersey Pharmaceutical Association. A discussion took place but no action ensued.

A special session featured Mr. F. Milmoe Brown, Life Insurance Consultant, who discussed Estate Planning.

Elected to office for the administrative year of 1956-1957 were the following:

Dr. John E. Annitto, President; Dr. Harold Gorenberg, President-Elect; Dr. Charles E. Rosen, Secretary; Dr. Charles A. Landshof, Treasurer; Dr. Harold C. Benjamin, Reporter.

HAROLD C. BENJAMIN, M.D.
Reporter

Morris

The *Morris County Medical Society* held its annual meeting at Spring Brook Country Club on Thursday evening, June 21. A golf tournament preceded the meeting and the golfers all received prizes for proficiency.

Dinner was served after the tournament and then the business meeting was chaired by Dr. Harold Hatch, President.

Guests from The Medical Society of New Jersey included Dr. Butler, immediate past president, Dr. Fritts, President, Dr. Bowers (from Morris County) second vice-president, Dr. McCall, treasurer, Mr. Nevin, executive officer. Other guests included Dr. Spurgeon from Newton and Dr. Buchanan from Phillipsburg.

The Society took the following actions; annual dues raised $10 per year, agreed to attempt to recruit a group of physician subscribers to Medical-Surgical Plan of New Jersey, sent best wishes to Dr. Frank Pinckney, sent congratulations to Dr. David Allman, President-Elect of the American Medical Association.

Dr. Abraham read a report of the convention of the State Medical Society.

A slate of officers and delegates for the coming year was elected and Dr. George Nicoll took the office of President.

ALBERT ABRAHAM, M.D.
Reporter

Passaic

The annual meeting of the *Passaic County Medical Society* was held on May 22 at the Medical Society Building. President Joseph R. Jehl presided. Dr. Florence Slaff was elected to active membership, Dr. George L. Becker, Jr. of Paterson, as associate.

Elected to office for the year 1956-1957 were:

President, Abraham Shulman, M.D.; First Vice-President, Samuel C. Yachnin, M.D.; Second Vice-President, Theodore K. Graham, M.D.; Secretary, Joseph F. Moriarty, M.D.; Treasurer, Frank B. Vanderbeek, M.D.; Reporter, David B. Levine, M.D.; Board of Censors (3 years) Joseph R. Jehl, M.D.; Building Trustees (3 years) Drs. Francis W. Ash, John A. Ianacone, Harry Wolfson, Sandor A. Levinsohn.

Dr. Weintraub read the following resolution on the death of one of the members of the Society. It was adopted as read:

Doctor Meyer Notkin, Paterson, died unexpectedly at the age of 49, on April 25, 1956.

A prominent civic and professional figure in his community, Dr. Notkin's death has been a great loss to his colleagues, patients and many friends.

Dr. Notkin was a graduate of the public schools of Paterson, after which he attended the University of Michigan where he received a B.S. degree in 1928 and his M.D. degree in 1932. He interned at St. Joseph Hospital, Paterson, and was a member of the medical staff of that institution throughout his professional career. He was in the Army of the United States from May 1941 to January 1946 and was discharged as a Major. In 1946 he became a member of the American Board of Internal Medicine and in 1953 a Fellow of the American College of Cardiology. When the Passaic County Heart Association was founded, Dr. Notkin was an instrumental and extremely active figure in its formation and organization, serving first as Treasurer, then as President in 1953 and 1954.

A conscientious, capable physician, a person of friendliness and charm, Dr. Notkin will be missed by all who knew him.

Be It Resolved: That the Passaic County Medical Society deeply regrets the passing of its esteemed member, and extends its sincerest sympathy to the bereaved family, and

Be It Further Resolved: That these resolutions be spread in full in the minutes of the Passaic County Medical Society, and a copy be sent to the family of the deceased.

The President briefly reported on the Annual Meeting of The Medical Society of New Jersey.

He brought the following matters to the attention of the members for consideration:

The establishment of a new policy of donating to a national fund for medical education, in lieu of sending flowers to the family, at the death of a member.

The availability of government booklets on the Alaska Mental Health Bill situation, with which subject he urged the members to get better acquainted.

The purchase of Automobile Emblems of the Society was again suggested.

The sale of cook books by the Woman's Auxiliary was brought to the members' attention. The books are available at the Society office and proceeds will go to the Nurse Scholarship and philanthropic funds.

Dr. Jehl then turned the meeting over to Dr. Louis J. Bohl who introduced the speaker of the scientific session, David M. Bosworth, M.D., Professor and Director of Orthopaedic and Traumatic Surgery, N. Y. Polyclinic Medical School and Hospital; Attending Orthopaedic Surgeon and Director of Orthopaedic Service, St. Luke's Hospital. The discussors were: Hon. John C. Wagner, Supervising Deputy Director, Division of Workmen's Compensation and Andrew Ruoff, Sr., M.D., Union City, N. J.

At the close of the question period, refreshments were served.

DAVID B. LEVINE, M.D.
Reporter

Book Reviews • • •

Essentials of Dermatology. By Norman Tobias, M.D. Edition 5. 651 pages. Philadelphia, Lippincott. ($8.00)

This text has been thoroughly brought up-to-date. It is an excellent reference book for medical students and general practitioners. The illustrations are new and excellent. Two unique and helpful features are included in most of the chapters. One is headed "Instructions to the Patient" and the other "Nursing Aspects." Both are neglected in most textbooks.

The psychosomatic aspects of skin diseases are presented simply and forcefully.

To be criticised is the use of proprietary names in most of the sections on therapy. This will lead to considerable confusion especially when a proprietary name is misspelled.

One inconsistency should be pointed out. On page 108, the dangers of Fowler's Solution are thoroughly documented. On page 139, there is a photograph of a child with an eruption, with the caption, "Disease responded to Fowler's Solution, administered for three months."

But in spite of a few inconsistencies, and in spite of the author's obsessional fondness for proprietary brand names, this is an excellent, modern dermatology textbook.

JACOB BLEIBERG, M.D.

Every Other Bed. By Mike Gorman. Cleveland, World Publishing Co. 1956. Pp. 319. ($4.00)

About half of all hospital beds are occupied by mental patients. That accounts for the title of this book: every other bed is occupied by a patient with emotional illness. The tide mounts and the only hope for reducing the incidence of mental disease is more research.

The American conscience ought to be stung about the poverty of its psychiatric research in the face of our glittering prosperity. And Mike Gorman is the man to sting us. The two needs in psychiatry are more personnel and more research. This book reviews the major problems in those two areas and, Mr. Gorman's hard hitting style, points to the possible solution. The author has a crotchet on biological psychiatry. He thinks that the hope for future research is in somatic medicine, not in epidemiology or psychodynamics. He lists what has been accomplished, particularly with the new drugs. He believes that the main factor in developing research is spending more money. He is sure that if "we get the money, the men will come."

The author pulls no punches in criticising American psychiatrists for pussy-footing or for being hide-bound by politics, tradition or stupidity. Instead of concentrating all his fire on the few basic evils, he diverts a lot of it to psychoanalysis and to the National Association for Mental Health — apparently Mr. Gorman's two private devils.

Much of the book is devoted to the tactical details of getting mental health legislation through Congress and through the several state legislatures. The author's own role as Executive Director of the National Mental Health Committee is not neglected in this account.

Mr. Gorman writes with assurance. He admits of no contingencies, and everything is black or white. Unfortunately the typical mental hospital is painted in very dark colors. Prospective recruits to the staffs of such hospitals should be denied access to this book. After he reads the snake-pit description here, no one would want to work in a "typical" public mental hospital.

HERBERT BOEHM, M.D.

What is Science? Edited by James R. Newman. New York, 1956, Simon and Schuster. Pp. 493. ($4.95)

Time was when medicine was considered a science. But here is a book which aims at giving "a balanced view of science and human values." It consists of 12 sections, each focused on a particular science. Not one contribution is by a physician. Even psychoanalysis, which is here considered a science, is presented by a nonphysician. So is the chapter on science and human life, the section on biochemistry (as distinct from a chapter on chemistry) and the chapter on genetics. Apart from this curious boycotting of medical men and medical science, the book is a good one. It does not talk down to its readers and does offer a thought-provoking picture of each of the scientific areas concerned. The book will be good only for those readers willing to read it slowly and thoughtfully.

HENRY A. DAVIDSON, M.D.

Hand Surgery in World War II. Edited by Sterling Bunnell, M.D. Prepared by the Historical Unit of the Medical Service of the U. S. Army. Government Printing Office, Washington, D. C., 1956. Pp. 447. With 224 illustrations. ($3.75)

This volume offers a survey of what has been learned in hand surgery and reconstruction. It discusses hand impairments as an induction factor in World War II, non-combat incurred hand injuries, and facilities for specialized care of hand injuries. Then there is a review of the incidence of hand injuries, observations on the organization of the special hand services, a report on defects after

treatment, recommendation for improved care, policies in the management of hand injuries, nerve injuries, plastic surgery on the hand, injuries of bones and joints, construction of new digits for prehension, injuries of tendons and muscles with and without transfer of tendons, vasomotor and trophic conditions, splinting and occupational therapy and rehabilitation.

The book also deals with hand injuries in various theatres of operation. Described is the initial care of hand injuries in forward areas, initial surgery in a forward hospital, reparative surgery at a general hospital, physical therapy, amputations, burns, frostbite, sequelae, infections, psychogenic factors and disposition of treated cases.

The book closes with a review of hand surgery at the nine "hand centers." Although primarily a reference source, this volume is a well-illustrated, precise, factual tribute to the United States Army surgeon and is a valuable addition to the library of all surgeons, civilian or military.

I. D. Rosenberg, M.D.

The Office Assistant in Medical or Dental Practice. By Portia Frederick and Carol Towner, Pp. 351. Philadelphia, Saunders. ($4.75)

How to write a check, put a patient in Trendelenberg, entertain a detail man, read roman numerals, and dispose of the doctor's vacation mail are all found in this meaty volume. Here is a text-book for formal training courses plus a self-help book for the self-trained. It is a portable how-to-do-it kit for the doctor's girl Friday. If she is a nurse, she will welcome the practical advice on bookkeeping credit extensions, and editorial duties. If she is a trained secretary, she will appreciate the book's tips on how to give hypodermics, conform to the narcotic laws, and handle autoclaves. The text covers office housekeeping and office bookkeeping; telephone technic and patient-draping technic; mail-handling and health insurance; medical ethics and medical supplies; library duties and the care of instruments. Your present office aide might be insulted at getting a copy, but she'd probably read it with edification. Altogether a unique volume that was just waiting to be written.

Victor Huberman, M.D.

Physical Diagnosis. By Ralph H. Major, M.D. and Mahlon H. Delp, M.D. Fifth Ed. Philadelphia 1956. Saunders. Pp. 358. ($7.00)

First, look at the patient. Then touch him. Then tap him. Finally, listen to him. These are the four methods of physical diagnosis—inspection, palpation, percussion, and auscultation. The authors, both professors of medicine (and medical detectives with a penchant for the practices of Sherlock Holmes) strongly favor working by the numbers.

So strongly, in fact, that they would not let a medical student own a stethoscope until he has studied physical diagnosis for six months.

Does this suggest a rigid piece of pedagogy? On the contrary, my dear Watson. It reads with surprising speed and clarity. Partly because the authors have followed Osler's razor: "And when you can, read the original descriptions of the masters who, with crude methods of study, saw so clearly." Partly because the authors themselves are skilled medical reporters—they write as well as they see.

Chapters have been shifted, parts of the text rewritten, and much new material (including photographs) added in the Fifth Edition. History Taking and Recording, formerly at the end of the book, now follows the introduction—testimony to its importance. Then there follow chapters on pain, general inspection, and examination of the chest, lungs and heart.

Pulse and blood pressure are discussed separately, as are physical findings in cardiovascular diseases, abdomen and genitalia, and examination of the nervous system.

But psychiatry takes a back seat. Less than two pages are devoted to "Psyche or Mental State," and the descriptions are inadequate and sometimes naive. ("Is the patient nervous, mentally alert and competent, or deranged, dull or stupid?"). Rather elementary, my dear Watson.

As a textbook of physical diagnosis, the book is a valuable guide for the medical student; a worthwhile tool for the practitioner.

Peter O. Garner

The Neuroses in Clinical Practice. By Henry P. Laughlin, M.D. Pp. 802. Saunders, Philadelphia, 1956. ($12.50)

This noteworthy book merits a place in the library of every practicing physician. Dr. Laughlin is a psychiatrist whose background includes accomplishment and experience in both teaching and private practice. His perceptive thinking is matched by an ability to write interestingly and with lucidity.

The result in this instance is an informative, very readable treatise on neuroses. The volume offers, as a preliminary, a discussion of emotional adjustment, mental mechanisms, and the origins, nature of, and defenses against anxiety. The clinical varieties of neuroses are then separately described and discussed. Case histories are judiciously used. There is an intriguing dissertation on "brain washing."

The appended glossary of psychiatric definitions and terms is unusual, and enlightening.

It is a minor criticism to regret the author's introduction of a few self-devised terms (e.g. King David reaction, Royal Canger) of doubtful import and necessity. On the whole, however, this work is an outstanding contribution to medical literature and deserves to be widely read.

J. Lawrence Evans, Jr., M.D.

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Vol. XXIX August, 1956 No. 8

Tuberculosis Study in Muscogee County, Georgia

By George W. Comstock, M.D., American Review of Tuberculosis, February, 1956.

Fast-tempo community wide roentgenographic surveys were developed with the hope that identification and treatment of many cases of asymptomatic tuberculosis would markedly improve control of tuberculosis in the surveyed community. During the past decade, with emphasis on this case-finding technique, the tuberculosis death rate has fallen markedly while the reporting of new cases has remained at a high level. The relation of fast-tempo surveys to these phenomena is still in question, and their effectiveness in helping to bring tuberculosis under control has been most difficult to measure.

One way to estimate the usefulness of a chest roentgenographic survey is to study the tuberculosis deaths in a community after the survey, particularly when tuberculosis mortality can be compared among the persons who were and were not examined. It is reasonable to suppose that tuberculosis mortality among participants and nonparticipants is related to the prevalence of tuberculosis among these groups and, consequently, might help to decide whether persons with tuberculosis participate in surveys to the same extent as do other members of the population.

In 1951 such an analysis was made of the tuberculosis deaths in Muscogee County, Georgia, for the three and one-half-year period after a community-wide chest roentgenographic survey. The important findings of that study may be summarized as follows: Mortality rates for both whites and Negroes decreased but slightly following the survey. Tuberculosis mortality among the surveyed and non-surveyed did not appear to be significantly different, leading to the inference that persons with tuberculosis participated in the survey program to approximately the same extent as did the general population. Death rates among persons with normal survey films revealed an unusually wide discrepancy between the two races: for white persons a low rate—approximately three per 100,000 population per year; for Negroes a rate thirteen times greater. The report tentatively concluded that subject to confirmation "a complete survey in a white population followed by adequate isolation might be so effective that for some time the tuberculosis control program in the community would consist chiefly of the provision of medical care and follow-up services to persons identified as tuberculous in the survey. For Negroes, it would seem that this would not be sufficient."

At the time of the 1951 analysis, it was recognized that the number of deaths and the length of the follow-up period were not sufficient and the study was extended for an additional three and one-half years.

The community-wide survey of 1946 and the subsequent follow-up procedures conducted by the

Muscogee County Tuberculosis Study had three notable features. First, the special census of 1946 made it possible to identify, among the 95,518 residents whether or not they obtained roentgenograms in the survey and allowed the identification of persons moving to Muscogee County subsequent to the 1946 program. Second, the roentgenographic screening during the seven years following the survey was quite extensive, including a second community-wide survey and eight surveys of special groups and a chest clinic screening program comprising about 20,000 roentgenograms each year. Even more important was the relationship with hospitals and private physicians which ensured that virtually all suspected cases of tuberculosis became known to the health department. Third, careful attention has been given to the verification of all reported tuberculosis deaths and to the investigation of all deaths in which tuberculosis might have been involved.

Pre-survey and post-survey mortality rates:

Tuberculosis mortality in Muscogee County is reported for three and one-half-year periods: one before the survey and two following it. From the first to the second period, the rate of decline in mortality among both races was somewhat less for Muscogee County than for the United States as a whole. From the second to the third period, the rate of decline among whites was greater than the national rate whereas for the Negroes it was approximately the same. In all periods, the mortality rates for both races were appreciably lower than those for the nation as a whole.

The difference in subsequent tuberculosis mortality between the portions of the population who had had chest films and those who had not was estimated. For both races, excluding those known to have had tuberculosis before the survey, the adjusted average annual tuberculosis mortality rates during the seven-year period following the survey were 24 per 100,000 among Muscogee County residents who had a survey film and 22 per 100,000 for those who did not. For whites, the rates were 8 and 10; and for Negroes, 63 and 50 respectively.

It seems likely that persons who had had survey films would have had their tuberculosis detected at a stage more favorable for treatment than those who were not examined. Consequently, one would expect a lower mortality among those who had had chest films than among those who had not. However, the mortality rates for whites were essentially the same in both groups, whereas Negroes with subsequently fatal tuberculosis were more concentrated among the surveyed population. These findings lend no support to the hypothesis frequently advanced that persons who have reason to believe they may have tuberculosis tend to avoid participation in chest roentgenographic surveys.

A comparison of the death rates among whites and Negroes with "positive" and "negative" survey films showed that the mortality rates for "survey positive" cases are rather high: 340 per 100,000 for whites and 1,490 for Negroes. In other words, approximately 2.5 per cent of the whites and 10 per cent of the Negroes with evidence of tuberculosis in their survey films have died of tuberculosis. It is obvious that tuberculosis is a serious disease even when discovered by examining an ambulant and largely asymptomatic population.

Among the population with normal survey films, the mortality rate for whites still remains low: 3 per 100,000 persons per year indicating that fatal tuberculosis was uncommon during the next seven years among white persons whose survey chest films were read as normal.

In striking contrast, the Negro rate is 45 per 100,000 persons per year for "survey negatives," 15 times that of the white "survey negatives," and essentially the same as that for the general Negro population in the last three and one-half years of the study period. This is strong evidence that a single survey of a Negro population, even when followed by an intensive tuberculosis control program aimed primarily at the cases discovered in the survey, is not sufficient to bring the disease under control.

An analysis of the deaths from tuberculosis in Muscogee County, Georgia, leads to the conclusion that a complete roentgenographic survey of a white population followed by adequate isolation of the infectious cases could reduce the tuberculosis control program, for several years at least, to the provision of medical care and follow-up services for persons identified in the survey as tuberculous. For a Negro population, it appears that case-finding programs should be repeated more frequently.

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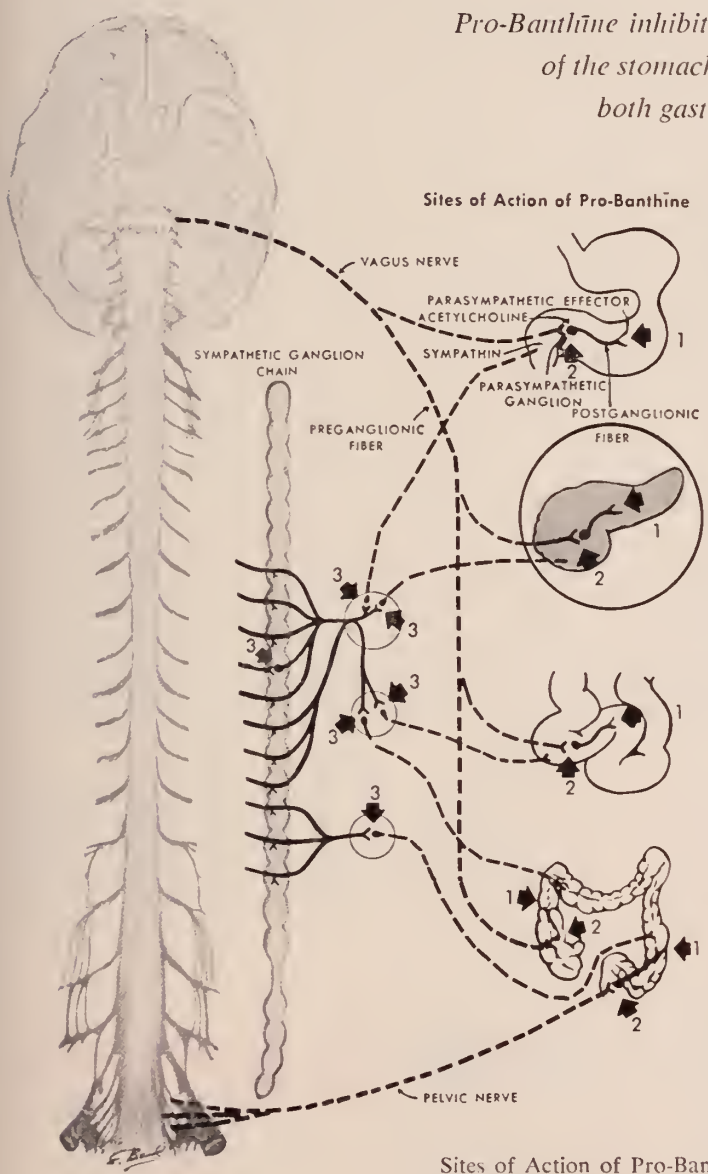
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1. Jones, C. A.: Arch. Int. Med. *96*:332 (Sept.) 1955.
2. Zollinger, R. M.: Postgrad. Med. *15*: 323 (April) 1954.
3. Woodward, E. R.: M. Clin. North America *38*:115 (Jan.) 1954.
4. Schwartz, I. R., and Hinton, J. W.: Personal communication. February, 1955.

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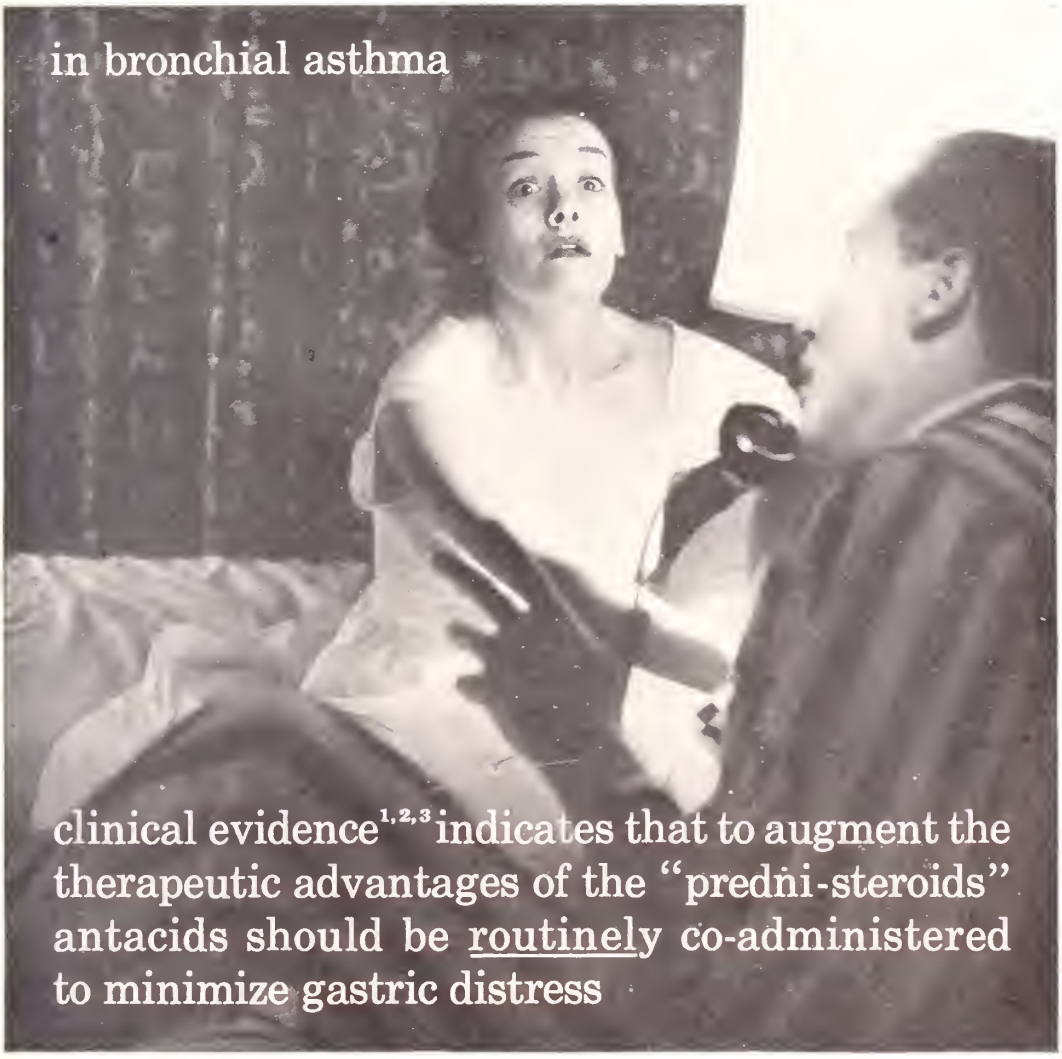
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*Moyer, J. H., and others:
J. Chronic Dis. 2:670, 1955.

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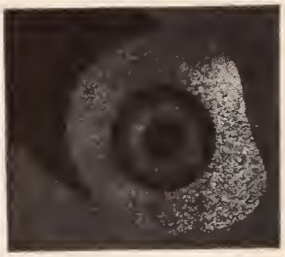
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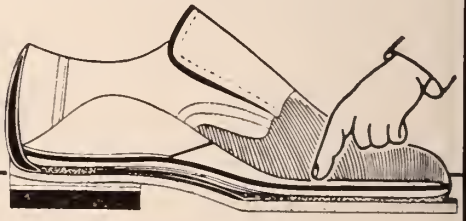
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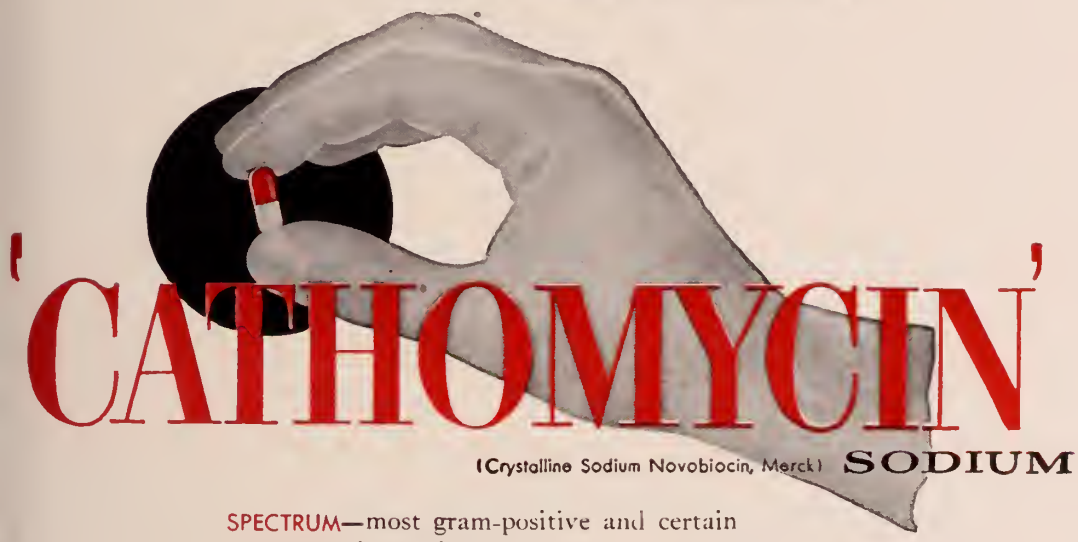
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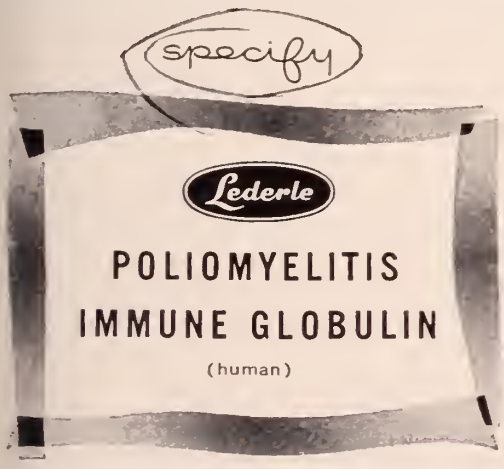
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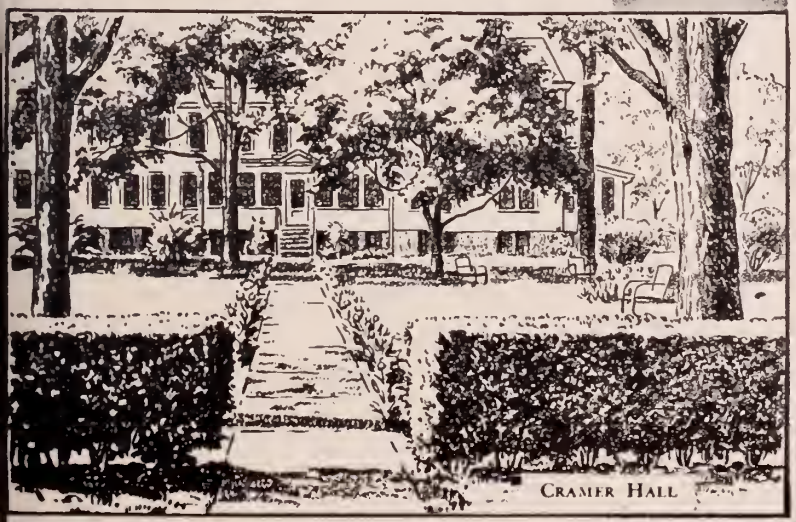
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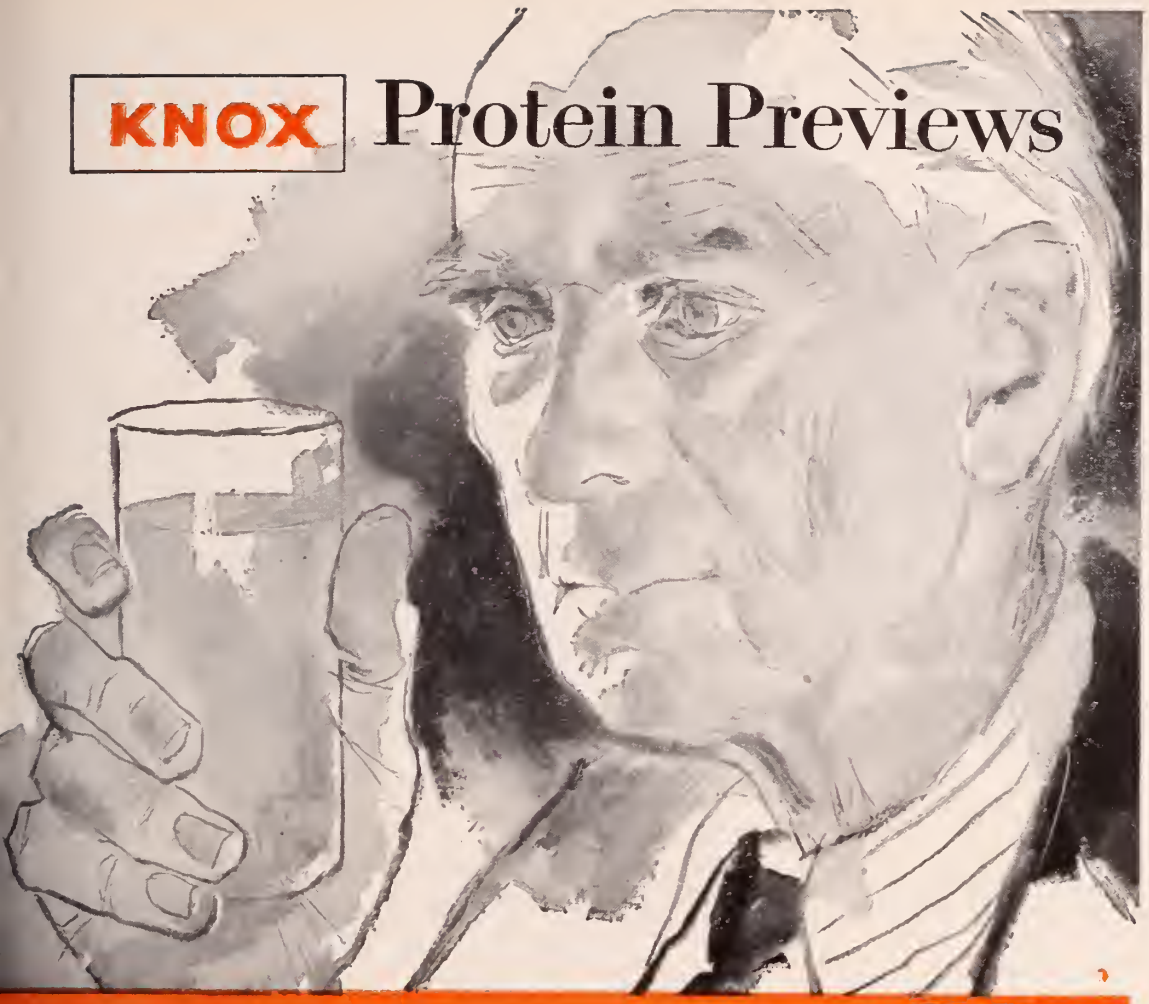
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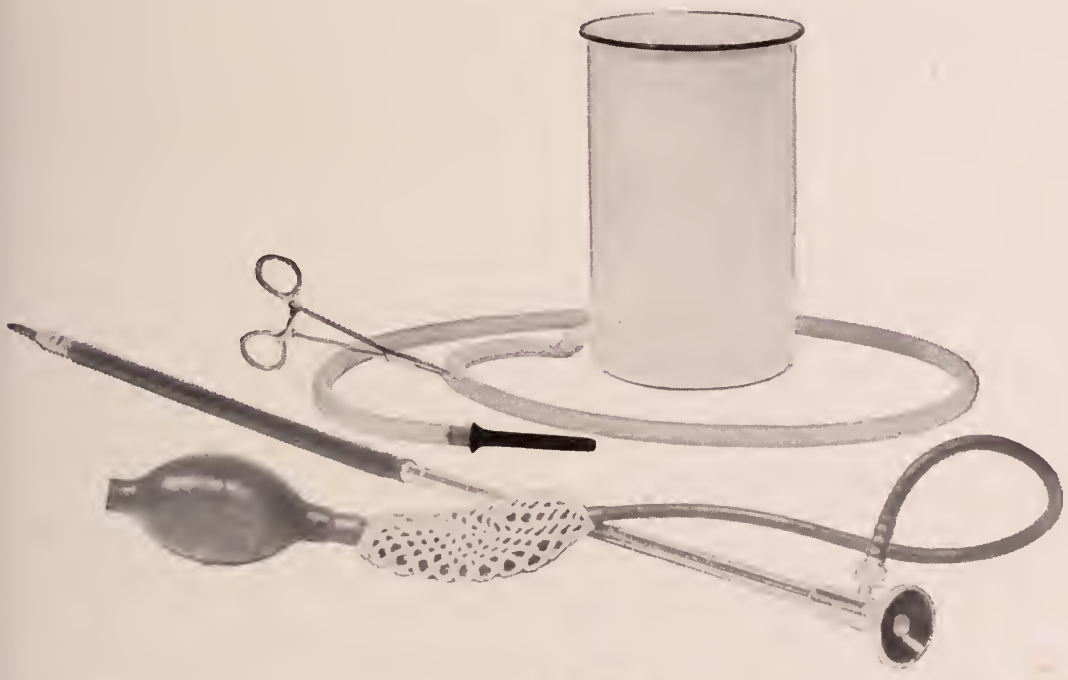
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On 7/7/55, the wound was saucerized and a hemolytic S. aureus (coag. +) was isolated from the osteomyelitis. Disc sensitivities were: penicillin, 10 units; erythromycin, 10 mcg.; tetracycline, 10 mcg.

On 7/15, the patient was placed on erythromycin therapy 400 mgm. q. 6. h. Patient afebrile after erythromycin started. X-rays showed evidence of healing with callus formation. No septicemia and clinical evidence indicates control of the infection.

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Diagnosis: fracture middle third of right femur, complicated by osteomyelitis.

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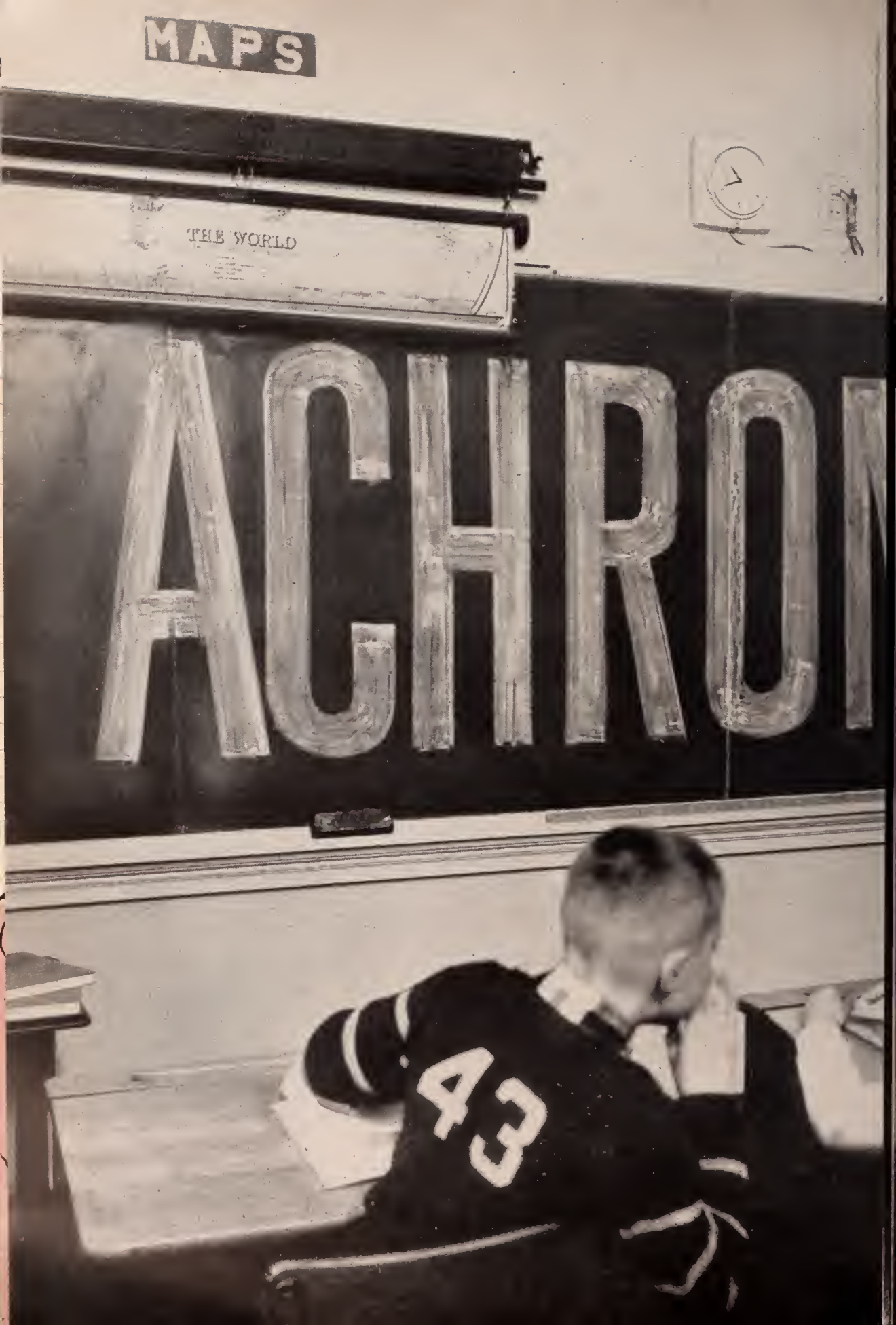
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January and his associates[1] have written on the use of tetracycline (ACHROMYCIN) to treat 118 patients having various infections, most of them respiratory, including acute pharyngitis and tonsillitis, otitis media, sinusitis, acute and chronic bronchitis, asthmatic bronchitis, bronchiectasis, bronchial pneumonia, and lobar pneumonia. Response was judged good or satisfactory in more than 84% of the total cases.

Each month there are more and more reports like this in the literature, documenting the great worth and versatility of ACHROMYCIN. This antibiotic is unsurpassed in range of effectiveness. It provides rapid penetration, prompt control. Side effects, if any, are usually negligible.

No matter what your field or specialty, ACHROMYCIN can be of service to you. For your convenience and the patient's comfort, Lederle offers a *full* line of dosage forms, including

ACHROMYCIN SF

ACHROMYCIN with STRESS FORMULA VITAMINS. Attacks the infection—defends the patient—hastens normal recovery. For severe or prolonged illness. Stress formula as suggested by the National Research Council. Offered in Capsules of 250 mg. and in an Oral Suspension, 125 mg. per 5 cc. teaspoonful.

For more rapid and complete absorption. Offered only by Lederle!

dry-filled sealed capsules

[1]January, H. L. et al: Clinical experience with tetracycline. *Antibiotics Annual* 1954-55, p. 625.

Lederle

LEDERLE LABORATORIES DIVISION
AMERICAN CYANAMID COMPANY
PEARL RIVER, NEW YORK

*REG. U. S. PAT. OFF.

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save the cigarette for later... Time was you had to wait for a local anesthetic to take hold —you waited, patient waited, nurse waited. **Now, rapid anesthesia....** Blockain* works so fast that clinicians had to describe it as "immediate" and "almost instantaneous." It's practically an understatement to call its action "rapid." **Longer anesthetic duration....** Besides being able to go to work sooner, you can work at an easier pace. Blockain lasts long enough so you can proceed from incision to closure on one injection. You finish up with a neat suture line undistorted by repeated instillations. The patient leaves uncomplaining and comfortable. ☞ *A busy clinician's experience with Blockain in fourteen cases of Colles' fracture:* A single 2-5 cc. injection of Blockain into the hematoma produced anesthesia in an average of 3 minutes 15 seconds. The average duration of these operations, closed reductions, was 25 minutes. Anesthesia persisted beyond the time required for reduction permitting splints to be applied, postreduction X-rays to be taken and the patients sent home feeling comfortable. **BLOCKAIN,** 30 cc., 0.5% (5 mg/cc.). Your office-ideal local anesthetic. For additional information write GEORGE A. **Breon** & COMPANY, 1450 Broadway, New York 18, N. Y.

*BLOCKAIN® BRAND OF PROPOXYCAINE HYDROCHLORIDE BREON.


widest
approach
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eye disorders
combines prednisolone and sulfacetamide
antibacterial
antiallergic
anti-inflammatory
also available as METIMYD Ointment with Neomycin
METIMYD,* brand of prednisolone acetate and sulfacetamide sodium.
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Ophthalmic
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perfect
fusion
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Sodium SULAMYD,® brand of Sulfacetamide Sodium U.S.P.
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2 Cases where **HI-PRO** is indicated

if you suspect infantile fat intolerance

A high-protein, low-fat diet is essential therapy. Hi-Pro is a mixture of spray-dried, defatted and specially delactosed cow's milk which provides your patient with an easily digested, soft curd basic food. Unlike many protein milks, HI-Pro feeding will not produce acidosis.



for rapid control of infantile diarrheas

In the treatment of infantile diarrheas, a wealth of medical evidence indicates that a high-protein, low-fat diet is a simple but effective prescription. Hi-Pro is a valuable medical tool for optimum infantile nutrition with minimal gastric disturbances.

We invite you to give Hi-Pro a fair trial and discover its therapeutic advantages.

Please send for samples and complete information.

HI-PRO is available in 1-lb. and 2½-lb. vacuum packed tins at all pharmacies.

HI-PRO POWDER CONTAINS:

Protein	41.0%
Fat	14.0%
Lactose	35.0%
Minerals	6.5%
Moisture	3.0%
Calcium	1.15%
Phosphorous	1.65%
Potassium	1.17%
Calories	121
Calories per tbsp.	40

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For patient of intermediate or stocky type-of-build.

FOR AMBULATORY PATIENTS with INJURIES OR DISEASES of the LUMBAR SPINE



For patient of thin type-of-build.

CAMP lumbosacral supports are widely recommended by orthopedic surgeons and physicians.

An important factor in the good results reported from their use is that they extend downward over the sacro-iliac and gluteal regions. The Camp adjustment provides exceptional restraint of movement.

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in topical and ophthalmic infections

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brand

POLYMYXIN B—BACITRACIN OINTMENT

to insure broad-spectrum therapy with minimum allergenicity

For topical use: in ½ oz. and 1 oz. tubes.
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For Control of Acute Agitation



- In the acute alcoholic
- In the acute psychotic
- In the drug addict

A potent new agent in chemopsychotherapeutics, SPARINE has demonstrated a marked ability to calm and relax acutely agitated patients.[1,2] Without inducing disabling lethargy or dulling perception, SPARINE "... is effective in ... maintaining these subjects in a quiescent detached state. ..."[1]

Given intravenously, SPARINE rapidly brings patients under control. Given orally or intramuscularly, it promotes patient accessibility, fosters psychotherapeutic contact, and facilitates over-all management. Parenteral administration of SPARINE is not painful and does not cause tissue necrosis at the site of injection.

For intravenous, intramuscular, or oral administration

1. Fazekas, J.F., et al.: J.A.M.A. **161**:46 (May 5) 1956. 2. Mitchell, E.H.: J.A.M.A. **161**:44 (May 5) 1956.

NEW Potent Ataractic Drug

Sparine*

Hydrochloride

Promazine Hydrochloride

*Trademark

10-(γ-dimethylomino-*n*-propyl)-phenothiozine hydrochloride

Wyeth®

Philadelphia 1, Pa.

abnormal capillary permeability and fragility frequently occur in and are aggravated by...

habitual and threatened abortion

diabetic and other retinopathies

hypertension

gastrointestinal bleeding

certain respiratory infections

gingival bleeding; epistaxis

C.V.P. is a specific aid in the prevention and correction of capillary fault in such conditions

Each C.V.P. capsule
or each 5 cc. of syrup
(approx. one teaspoonful) provides:

Citrus Bioflavonoid Compound	100 mg.
Ascorbic Acid (vitamin C)	100 mg.

capsules: bottles of 36, 100, 500, 1000
syrup: bottles of 4 oz., 16 oz. and gallon

new!

duo-C.V.P.

(double strength C.V.P.)

Each duo-C.V.P. capsule provides:

Citrus Bioflavonoid Compound	200 mg.
Ascorbic Acid (vitamin C)	200 mg.

capsules: bottles of 50, 100, 500 and 1000

C.V.P.

and

duo-C.V.P.

(double strength C.V.P.)

C.V.P. helps diminish increased capillary permeability, fragility, and resultant bleeding by acting to maintain the integrity of the intercellular ground substance (cement) of capillary walls. C.V.P. is water-soluble and is thus readily absorbed and utilized. Purified hesperidin and rutin are poorly soluble in water. Hesperidin itself has been shown to be inactive in a number of biologic tests, in which C.V.P. is highly active. C.V.P. provides the many active water-soluble bioflavonoid factors of the whole citrus bioflavonoid complex.

SAMPLES on request

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(Arlington-Funk Laboratories, division)
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How to win friends ...



The Best Tasting Aspirin you can prescribe.

The Flavor Remains Stable down to the last tablet.

25¢ Bottle of 48 tablets (1¼ grs. each).

We will be pleased to send samples on request.

THE BAYER COMPANY DIVISION of Sterling Drug Inc. 1450 Broadway, New York 18, N. Y.



Taste is as important

to your young patients

as antibacterial

effectiveness

is to you...

Gantrisin Acetyl

Pediatric Suspension

'Roche'

Gantrisin® - brand of

sulfisoxazole

For patients pursued by their own emotions —



Noludar 'Roche' will help solve the problem. Not a barbiturate, not likely to be habit forming, 50 mg t.i.d. provides daytime sedation with little likelihood of somnolence, while 200 mg h.s. induces a sound night's sleep, usually without hangover. Noludar tablets, 50 and 200 mg; elixir, 50 mg per teaspoon.

Hoffmann - La Roche Inc
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Noludar®--
brand of methyprylon

for preventing and treating upper respiratory infections



new!

Achrocidin*

TETRACYCLINE-ANTIHISTAMINE-ANALGESIC COMPOUND

ACHROCIDIN provides in one tablet all the drugs which are often prescribed separately for the prevention and treatment of cold complications — conditions such as otitis, adenitis, sinusitis, and others.

This comprehensive formula 1) provides potent therapeutic and prophylactic action against a wide variety of infective organisms, 2) relieves pain and discomfort, 3) depresses fever, 4) alleviates nasal congestion.

Available on prescription only

Each tablet contains:

ACHROMYCIN® Tetracycline	125 mg.
Phenacetin	120 mg.
Caffeine	30 mg.
Salicylamide	150 mg.
Chlorothen Citrate	25 mg.

Bottle of 24 tablets.

Average adult dose: 2 tablets, 4 times daily

Lederle LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, NEW YORK

*TRADE-MARK

Meat...

and Its Place in the Diet in Congestive Cardiac Failure

Meat has an appropriate place in the moderate-protein, low-sodium, acid-ash diet advocated in the dietary management of patients with congestive cardiac failure.[1] When extreme sodium restriction is necessary, the meat allowance is regulated accordingly.

Lean meat allows maintenance of a positive nitrogen balance without excessive protein intake, because its amino acids match the quantity and proportions needed for tissue synthesis and repair.[2,3] In the fresh state as purchased it supplies only small amounts of sodium ranging from approximately 50 to 100 mg. per 100 grams. Due to its acid-ash composition (equivalent to 4 to 38 ml. of normal acid per 100 grams of meat) it may facilitate diuresis.[1]

In addition to these important features, meat contributes valuable nutritional factors by virtue of its generous supply of high quality protein, B vitamins, and essential minerals—iron, phosphorus, potassium, and magnesium.

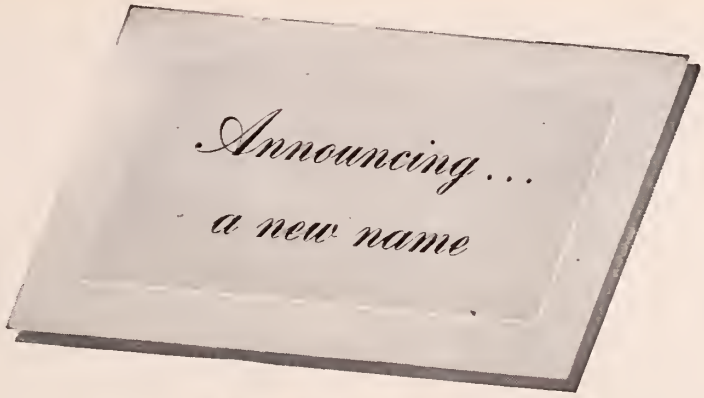
Easy digestibility, a prime requisite of foods eaten by the patient with congestive cardiac failure, is another outstanding quality of meat.

---

1. Odel, H. M.: Nutrition in Cardiovascular Disease, in Wohl, M. G., and Goodhart, R. S.: Modern Nutrition in Health and Disease, Dietotherapy, Philadelphia, Lea & Febiger, 1955, p. 709.
2. Berg, C. P.: Utilization of Protein, J. Agr. & Food Chem. *3*:575 (July) 1955.
3. Best, C. H., and Taylor, N. B.: The Physiological Basis of Medical Practice, ed. 6, Baltimore, Williams & Wilkins, 1955, p. 638.

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

American Meat Institute
Main Office, Chicago...Members Throughout the United States



'LANOXIN'
brand
DIGOXIN

formerly known as Digoxin 'B. W. & Co.'®

The new name has been adopted
to make easier for everyone
the distinction between
Digoxin and Digitoxin.

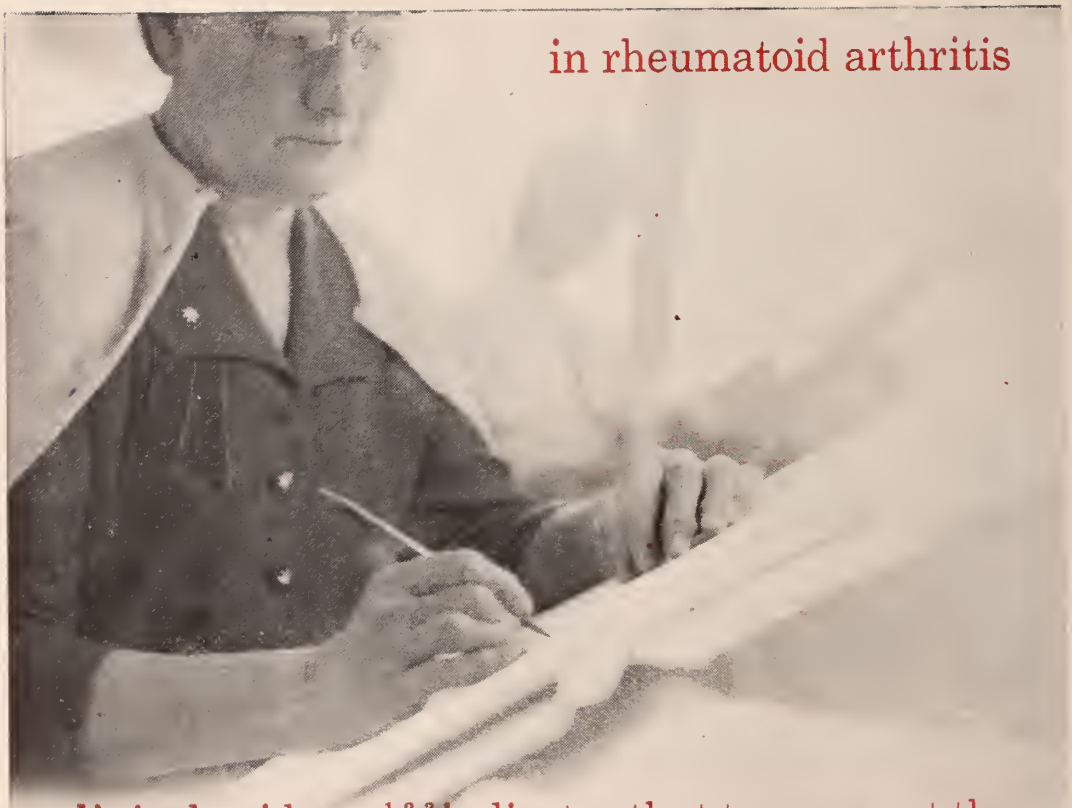
Now simply write:

'Lanoxin' Tablets 0.25 mg. or 0.5 mg.
'Lanoxin' Elixir Pediatric, or
'Lanoxin' Injection

to provide the unchanging safety and predictability afforded by the uniform potency, uniform absorption, brief latent period and optimum rate of elimination of this crystalline glycoside.

Tablets:	*0.25 mg. (white) and 0.5 mg. (green)*
Elixir Pediatric:	*0.05 mg. in each cc.*
Ampuls:	*0.5 mg. in 2 cc.*

BURROUGHS WELLCOME & CO. (U.S.A.) INC., *Tuckahoe, New York*

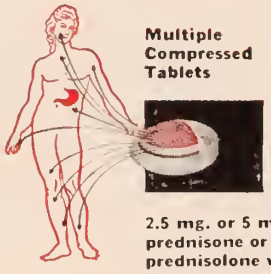


in rheumatoid arthritis

clinical evidence[1,2,3] indicates that to augment the therapeutic advantages of the "predni-steroids" antacids should be routinely co-administered to minimize gastric distress

ROUTINE CO-ADMINISTRATION MEANS

'Co-Hydeltra'
(Prednisolone Buffered)



Multiple Compressed Tablets

2.5 mg. or 5 mg. prednisone or prednisolone with 50 mg. magnesium trisilicate and 300 mg. aluminum hydroxide gel.

'Co-Deltra'
(Prednisone Buffered)

All the benefits of the "predni-steroids" plus positive antacid action to minimize gastric distress.

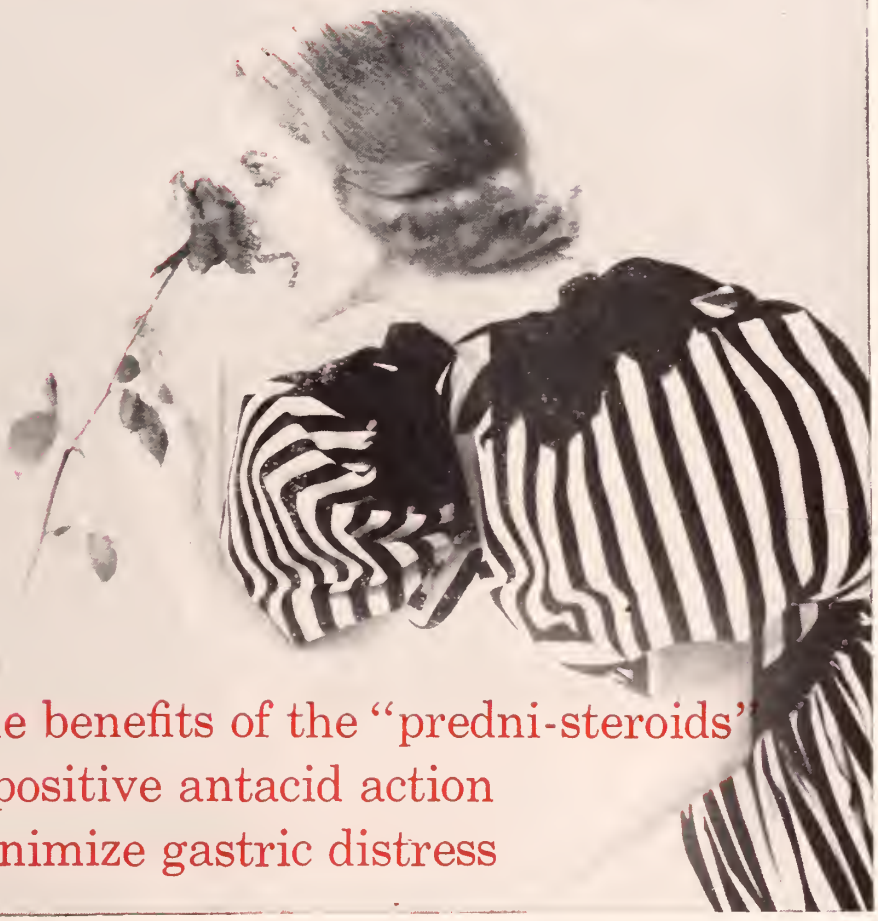
References: 1. Boland, E. W., *J.A.M.A.* 160:613 (February 25) 1956. 2. Margolis, H. M. *et al.*, *J.A.M.A.* 158:454 (June 11) 1955. 3. Bollet, A. J. *et al.*, *J.A.M.A.* 158:459 (June 11) 1955.

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DIVISION OF MERCK & CO., INC.
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in respiratory allergies



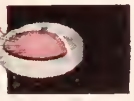
all the benefits of the "predni-steroids"
plus positive antacid action
to minimize gastric distress

ROUTINELY ACHIEVED WITH

'Co-Deltra'
(Prednisone Buffered)



Multiple Compressed Tablets



'Co-Hydeltra'
(Prednisolone Buffered)

2.5 mg. or 5 mg. prednisone or prednisolone with 50 mg. magnesium trisilicate and 300 mg. aluminum hydroxide gel.

Clinical evidence[1,2,3] indicates that to augment the therapeutic advantages of prednisone and prednisolone, antacids should be *routinely* co-administered to minimize gastric distress.

References: 1. Boland, E. W., *J.A.M.A.* 160:613 (February 25) 1956. 2. Margolis, H. M. *et al.*, *J.A.M.A.* 158:454 (June 11) 1955. 3. Bollet, A. J. *et al.*, *J.A.M.A.* 158:459 (June 11) 1955.

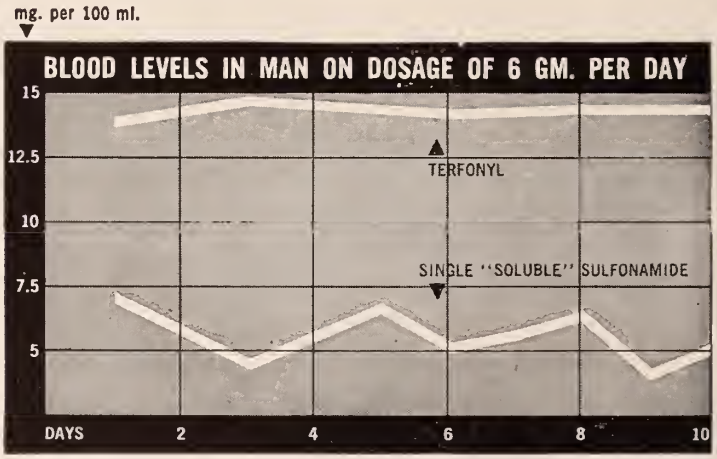
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maximum efficacy with minimum risk

Terfonyl

SQUIBB METH-DIA-MER SULFONAMIDES



– After Lehr, D., Modern Med. 23:111 (Jan. 15) 1955.

Terfonyl is absorbed as well as single "soluble" sulfonamides, but is eliminated at a slower rate. For this reason, Terfonyl blood levels are much higher.

In experimental infections (Klebsiella, Pneumococcus, Streptococcus), Meth-Dia-Mer sulfonamides have been shown to be from three to four times more effective on a weight basis than single "soluble" sulfonamides.

Toxicity is minimal because normal dosage provides only one-third the normal amount of each sulfonamide. The body handles each component as though it were present alone, although therapeutic effects are additive.

Terfonyl Tablets, 0.5 Gm., bottles of 100 and 1000.
Terfonyl Suspension, 0.5 Gm. per 5 ml., pint bottles.

0.167 Gm. each of sulfamethazine, sulfadiazine and sulfamerazine per tablet or per 5 ml. teaspoonful of suspension.

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"TERFONYL"® IS A SQUIBB TRADEMARK

Introducing

A.P.C. WITH Demerol® Tablets

for more efficient

CONTROL OF *Pain*

Each tablet contains:

Aspirin	200 mg.	(3 grains)
Phenacetin	150 mg.	(2½ grains)
Caffeine	30 mg.	(½ grain)
Demerol hydrochloride	30 mg.	(½ grain)

Average Adult Dose: 1 or 2 tablets
repeated in three or four hours as needed.

Bottles of 100 tablets. *Narcotic blank required.*

"Such a combination has proven clinically to be far more effective and no more toxic than equivalent doses of any of these used singly."*

Winthrop LABORATORIES
NEW YORK 18, N. Y.

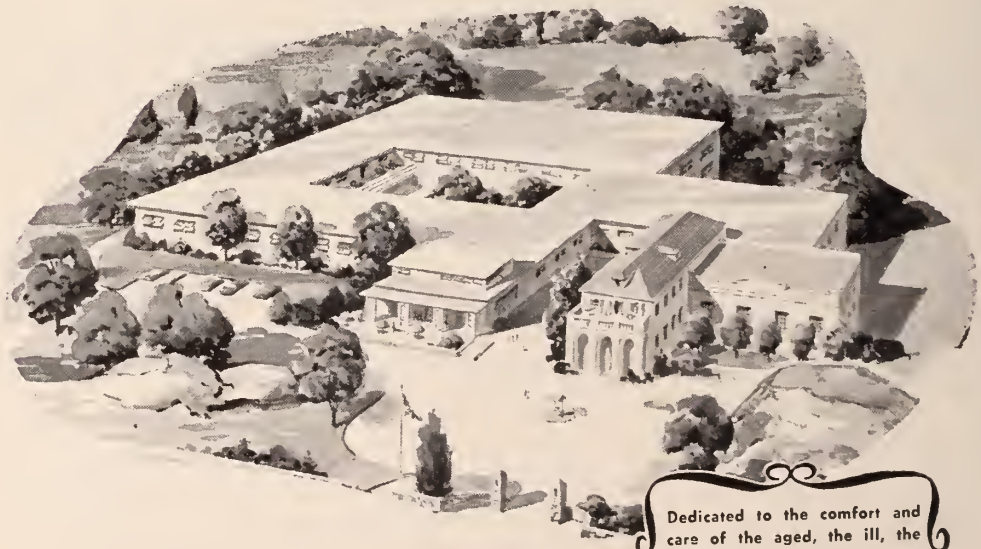
*Bonica, J.J.; and Backup, P.H.: Northwest Med., 54:22, Jan. 1955.

Demerol, trademark reg. U.S. Pat. Off., brand of meperidine.—

Alps Manor
NURSING HOME

ON ALPS ROAD, PREAKNESS, WAYNE TOWNSHIP, NEW JERSEY

. . . the Ultimate in Care



Dedicated to the comfort and care of the aged, the ill, the handicapped and the convalescent.

In a quiet, country setting of beautiful lawns and gardens . . . with a carefully planned program to meet the personal requirements of each guest. . .

- **Spacious, Airy Rooms**
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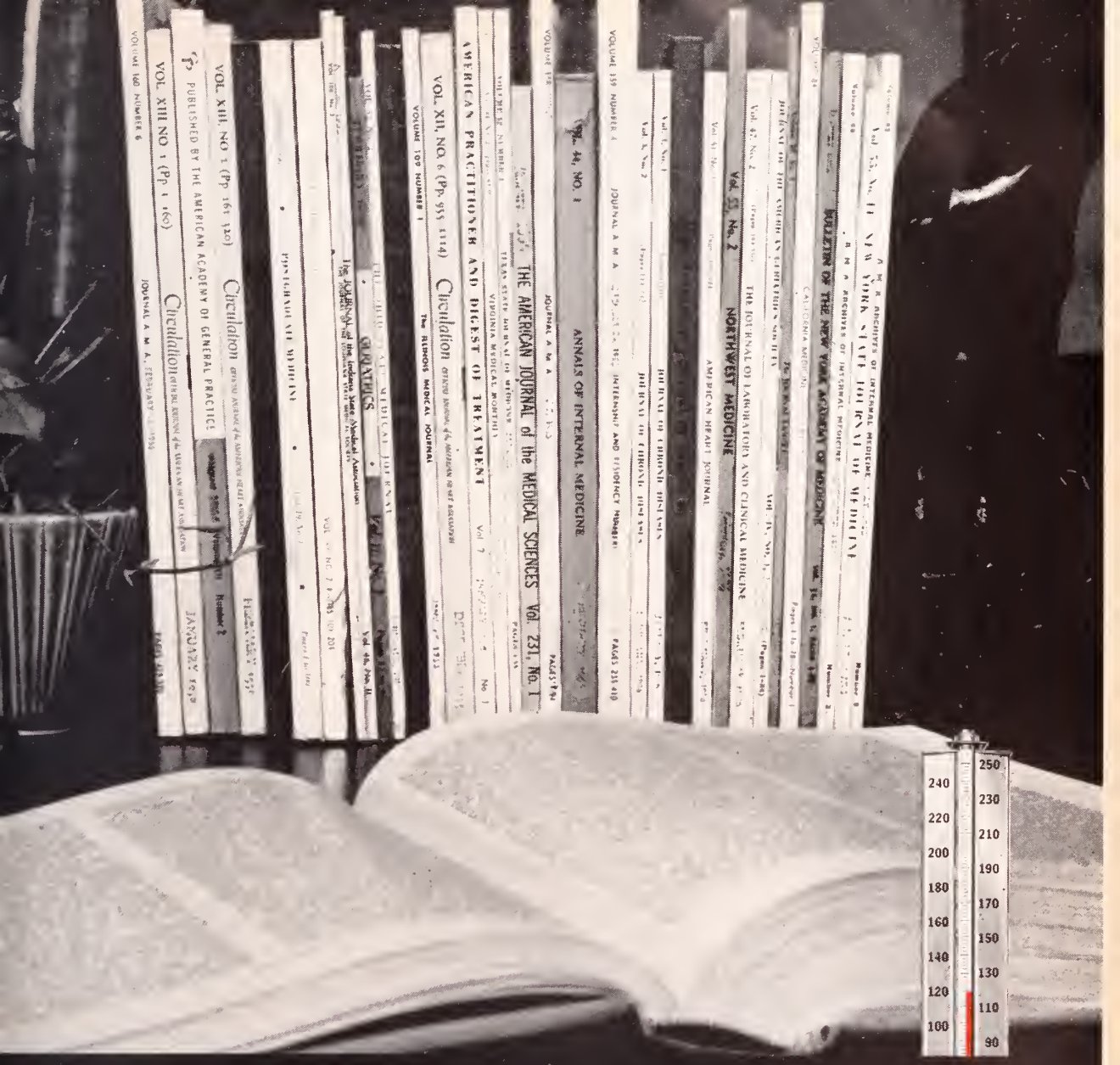
Private Consulting and Treatment Rooms for Patient's Own Physician

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DR. JEAN KAPLAN, Director

Phone: Mountain View 8-2100

DIRECTIONS: Route 46 to Route 23, turn right and continue on Route 23 to Alps Road, turn right on Alps Road to Nursing Home.



From the Literature

"... the most effective antihypertensive agent available."[1]

"... a simple and safe regimen for the ambulatory management of hypertensive patients."[2]

"... reduction of the blood pressure may be achieved in substantially all forms of hypertension."[3]

"... possible in most patients to get a good control over blood pressure levels with comparatively few side-effects."[4]

"... significant falls ... occurred in systolic and diastolic blood pressure. ... The cardiac, retinal and coronary status of all patients was improved."[5]

1. Moser, M.: New York State J. Med. 55:1999 (July 15) 1955. 2. Agrest, A., and Hoobler, S.W.: J.A.M.A. 157:999 (March 19) 1955. 3. Smirk, F.H.: Am. J. Med. 17:839 (Dec.) 1954. 4. Smirk, F.H., and McQueen, E.G.: J. Chron. Dis. 1:516 (May) 1955. 5. Waldman, S., and Pelner, L.: Am. J. M. Sc. 231:140 (Feb.) 1956.

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TARTRATE

Pentolinium Tartrate

Lowers Blood Pressure

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recognized

as a potent, specific anti-arthritic

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BUTAZOLIDIN®

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potent, specific anti-arthritic

Based on an impressive background of achievement attained over a period of four years involving both long-term and short-term therapy in all the major forms of arthritis, BUTAZOLIDIN is recognized as one of the most effective anti-arthritic agents currently available.

relieves pain

improves function

resolves inflammation

BUTAZOLIDIN being a potent therapeutic agent, physicians unfamiliar with its use are urged to send for literature before prescribing it.

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72556



SERPHYLLINE T.M.

'Enteric-Coated' Tablets

(Blair brand of reserpine-aminophylline)

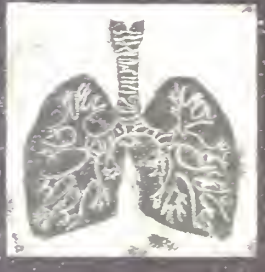
TO RESTORE EMOTIONAL TRANQUILITY AND REINFORCE CARDIO-PULMONARY FUNCTION IN ARTERIOSCLEROTIC AND HYPERTENSIVE HEART DISEASE, ANGINA PECTORIS, PAROXYSMAL (NOCTURNAL) DYSPNEA, AND PULMONARY EMPHYSEMA

Formula—each tablet combines:

Reserpine, crystalline	0.1 mg.
Aminophylline (in enteric-coated core)*	100.0 mg. (gr. 1½)

Supply—bottles of 100 tablets

...a preferred prescription whenever oral aminophylline is indicated...



SERPHEDRINE T.M.

'Enteric-Coated' Tablets

(Blair brand of reserpine-aminophylline-ephedrine)

SYNERGISTICALLY ENHANCED SAFETY AND EFFECTIVENESS FOR PROMPT AND PROLONGED RELIEF OF ANXIETY AND BRONCHO-PULMONARY DYSFUNCTION IN BRONCHIAL ASTHMA, PULMONARY EMPHYSEMA, AND CHRONIC BRONCHOPULMONARY DISORDERS

Formula—each tablet combines:

Reserpine, crystalline	0.1 mg.
Aminophylline (in enteric-coated core)*	100.0 mg. (gr. 1½)
Ephedrine sulfate	16.0 mg. (gr. ¼)

Supply—bottles of 100 tablets

...preferred whenever oral aminophylline-ephedrine is indicated...

*To help avoid gastric irritation and prolong protection.

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HERE'S WHY SO MANY DOCTORS NOW SMOKE AND RECOMMEND

VICEROY



Twice as Many Filters

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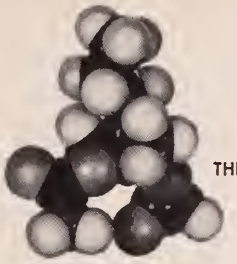


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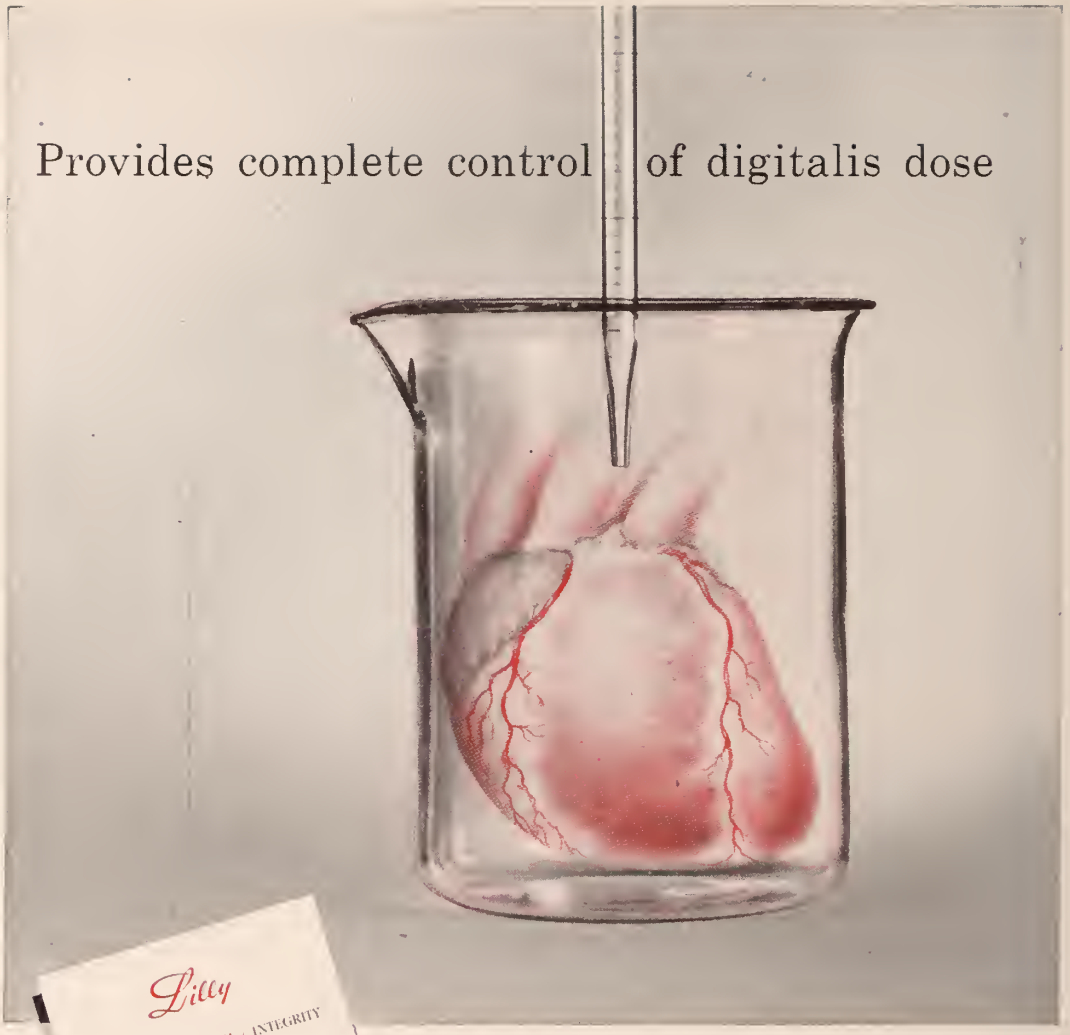
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THE JOURNAL
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Editorials • • •

All the Drowsy Syrups of the World

Every second American, according to a Gallup poll, has trouble falling asleep. At least, every second American *thinks* he has such trouble—and that's practically the same thing. Modell* estimates that insomnia is the third commonest of all medical complaints—being outnumbered only by pain and anxiety. Since pain prevents sleep, and anxiety is often the fruit of insomnia, it may be said that sleeplessness comes close to being the number one complaint in all medicine. Modell* says that Americans swallow about 2½ million doses of barbiturates every day. If half of these are intended to facilitate sleep (surely a conservative estimate) it would seem that more than a million of our fellow-citizens suffer from insomnia.

Insomnia is terrifying to all but the most philosophical. Minutes are stretched into hours, and the darkness clothes our thoughts with somberness. The harder one tries to sleep, the tenser he becomes. The more tension, the less sleep. In every other activity, it is sound advice to strive, to try hard and to go in there punching. But not when one is courting sleep. No emperor can buy a moment's natural sleep for all the gold in his coffers. The poorest beggar may enjoy a boon denied his emperor. Once he does get to sleep, there is no difference between the king and the slave.

It is a common grievance that whatever you like is bad for you. This is the complaint that attaches itself to the pleasures of wine, women, and gluttony. But sleep is an exception. Here, at last, is one thing people like—that is truly good for them.

(Continues overleaf)

*Modell, Walter: *The Relief of Symptoms.* Saunders, Philadelphia 1955.

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Sleep should be the easiest of all processes to investigate. Every one is asleep a third or a fourth of his life, and people for study are all around us. In spite of the accessibility of subjects, sleep's mystery remains unsolved.

Studies have been made of persistent forced sleeplessness. Compulsory vigil produces hallucinations, amnesia and various schizoid symptoms. This is true even if the subject rests and relaxes. The magic, it seems, lies in the impairment of consciousness. There are reams of literature about the physiologic concomitants of sleep—the slower heart rate, the lowered body temperature, the drop in blood pressure, and minimization of muscle tone, the reduction in metabolism generally. But these tell us nothing of the inner experience, the flight from conscious contact with reality. The electro-encephalogram shows distinctive brain wave patterns in sleep. Very pretty tracings are produced and they differ from tracings in the waking state. These tracings paint a pictorial cryptogram of brain action. But no one has found the key to the cryptogram.

How does the body accomplish this nightly miracle? Some say it is a matter of cerebral anemia—a fine theory, except for the fact that the brain gains blood volume during sleep. Maybe though, that blood is less well oxygenated. Or maybe the brain gains blood as a whole because certain parts of that organ are drained of blood. If you don't like that theory, how about the fatigue toxin? A tired man feels toxic, and perhaps fatigue sends poisons into the brain. Or, could it be that neurones withdraw from each other, and these briefly broken synapses interrupt cerebral function? Or maybe sleep is simply the end of a chain of reflex inhibitions resulting from over-stimulation: a kind of conditioned reflex mechanism.

Perhaps we are approaching this the wrong way. Sleep is such a boon that we try to find what causes it. But let us look at it the other way. The remarkable thing is not that we sleep but that we stay awake. Nathaniel Kleitman, indeed, has it that there is a special diencephalic center—not, if you please, a sleep center, but rather a wake center. This stays in action because it is constantly bombarded with impulses. When this process stops—when muscles tire, the room darkens, attention flags, noise is softened, when all this happens, the wake center is no longer stimulated and finally it suspends operations for the night. And then the normal state of sleep takes over.

How to induce sleep? You can take a warm bath, buy a noise absorbing box, lie on an especially hard—or especially soft—mattress. You can count sheep, lie on your right side, take barbiturates, do without a pillow or try an especially big pillow. You can use ear plugs or drink hot milk. You have indeed, a mad choice of frenzied activity by which you can woo this unreliable goddess. Unhappily, the more feverish the activity, the less successful the wooing.

Sleep is an essential of life, yet, as Homer writes, it is the twin of death. Sleep is needed to make us healthy, and presumably without health there is no wealth. So sleep, in one sense, leads to prosperity. But *Proverbs* warns "Love not sleep lest thou come to poverty," and Poor Richard admonishes: "Up, sluggard; waste not of life: the grave will be sleeping enough."

Sleep is associated with pleasant passivity; yet when followed by the preposition "with," it is also a symbol of pleasant activity. This curious association of sex and sedatives lends yet another dimension to sleep. One is here reminded of Judge Donahue's dictum when he ruled that *Forever Amber* could be sold in Massachusetts. "This book," he wrote, "acts like a soporific not like an aphrodisiac. While conducive to sleep, it is not conducive to desire to sleep with a member of the opposite sex."

Throughout the world, pharmaceutical companies are toiling to find the perfect hypnotic —to make what Shakespeare called one of "the drowsy syrups of the world." The opiates have had their day—or night—as bringers of the balm; and then came the bromides, latterly the barbiturates, and now a rainbow of tranquilizers, soothers, soporifics and sedatives. Each new drug is hailed with the most flattering of all claims: that it closely imitates nature, producing "natural" sleep. Relentlessly the search for the perfect soporific is pressed. Some day it may lead to a wonder drug that will copy

natural sleep even as a formula copies mother's milk.

Everywhere, every day a patient poignantly pleads with his doctor to bring sleep into his nights. The cry is for that sleep which "knits up the ravelled sleeve of care." Or as Philip Sidney so gracefully puts it:

" . . . that certain knot of peace,
The baiting place of wit, the balm of woe
The poor man's wealth, the prisoner's release,
Indifferent judge between the high and low . . ."

It is so easy to prescribe the newest sedative. It takes little of the doctor's time — a scrawl on an Rx blank and it's done. And there is always the detail man to tell you how to spell the trade-name and how it is packaged.

Yet half the time the insomnia is but a paraphrased anxiety — an anxiety that yields to understanding, to unhurried conversation, to help in teaching calm and relaxation. This is the greater boon, if we but had the time to confer it on all our patients. But this tense world makes insomniacs of many of us, and creates an age of anxiety. Perhaps as Nathaniel Hawthorne said just 100 years ago: "The world should recline its vast head on the first convenient pillow and take a long, long nap."

You Can't Win

They blame us for so many other things. Now they accuse us of generating disease. They even have a word for it: iatrogenesis. "Created by physicians"—says the dictionary.

The mahatmas tell us that there are three kinds of iatrogenesis. First class iatrogenesis is a purposely produced minor ailment—like vaccinia—to protect against a major one—like small-pox. Then there's grade-2 iatrogenesis, where illness follows as an accidental untoward effect: like anaphylactic reaction to an antibiotic.

But the worst kind of iatrogenesis, the kind they are always scolding us about, is anxiety or hypochondriasis produced or aggravated by the doctor's way of "handling" the patient.

It's like this. Suppose you are listening to a chest. You mutter, mostly to yourself: "aha!"

That's bad. The patient can interpret the remark as indicating that you have finally found a long lost heart lesion. If instead of saying 'aha' you just grunt, that's misinterpreted too.

But suppose you don't make any sound. No good. *That* can also cause hypochondriasis. An ominous silence, you see.

Or take iatrogenic hypertension. Don't you like *that* fancy phrase: iatrogenic hypertension. You can produce it just by taking a blood pressure.

The patient is, say, 52 years old. You find a systolic pressure of 160. Means nothing, of course. The patient asks: "What's my blood pressure?"

If you say "160," he will have heard of the "100 plus your age" rule. He figures he ought to have a blood pressure of 152. So, you've frightened him into iatrogenic anxiety, and that *does* send the blood pressure up.

If you say "Your blood pressure is 148" you will be telling a lie, and thus destroy the whole fabric of the doctor-patient relationship. See any text on ethics.

If you remain mute or give an evasive answer—like saying "Oh, your blood pressure is nothing to worry about"—if you do that, you produce anxiety because the patient thinks you are trying to conceal something.

Oh for the good old days when the doctor was expected to relieve illness not cause it!

You can't win.

Do You Identify With Patients?

Any time you want to get into an old-fashioned staff room argument, ask whether the doctor ought to identify with his patients, and be an intimate part of community life at their level, or whether he should stand aloof and above the crowd. For instance, in an agricultural county, should the doctor know how to milk a cow and have a real interest in farming minutiae? In a heavy industrial sector, should the doctor know something about the daily life of a skilled machine worker? If the doctor has his office in a slum area, or in an area where most of the people are ill educated, should he maintain his superior position as the one educated man among them, or should he join in their community organizations and take an intimate part in their daily lives? Does he, under those circumstances, win more respect by sending his children to the schools in that neighborhood? Or does he win more respect by sending them to private schools or, by paying the tuition, to schools in a more favored neighborhood? For that matter, does he lose or gain in community stature if he keps his office there but his home in a well manicured suburb?

Any one have the answer?

Lower Death Rates Mean More Medical Care

Since the turn of the century there has been an overall decline of 92 per cent in death rates from all communicable diseases! As a practical matter, communicable diseases have been virtually eliminated as a cause of death. These statistics come from a recent issue of *Progress in Health Services*, the newsy little bulletin put out by the Health Information Foundation.

All men must die. When we reduce deaths from infectious diseases and other acute ailments, we necessarily increase deaths from cancer and heart disease. There is no escape from this grim calculus. Our aim as doctors is only to postpone death. We cannot eliminate it. We all lose the war to the Reaper, but at least we want to let him know he has been in a fight.

What do you suppose were the three major causes of death in 1900? Don't look now, but write down your list first, then compare with the footnote.[1] The prime causes today are—in order: heart disease, cancer, and cerebral vascular lesions.

By rescuing youth from the lethal lesions of infancy and childhood, we have saved him for the assaults of cancer, and cardiovascular disease. Thus, there is greater need now than ever before for medical care. The baby who died of "summer complaint" in 1901 needed a doctor to stand helplessly at the bedside for a few days. The one who survived the summer of 1901 now needs medical-nursing-rehabilitative attention for his post-apoplectic palsy, his cardiac-crippled daily life, or his post-colostomy care. Also, we need vast amounts of health care for non-fatal chronic diseases like multiple sclerosis and certain arthridites.

Some day the Fire Department may put itself out of business by developing 100 per cent fire-proofing. Some day, we hope, the Government may put armies and navies out of business by devising 100 per cent war-proofing technics. But since we physicians are at war with an ultimately invincible enemy, we will always be needed. Let us continue to be worthy of that indispensability!

1. In 1900 the main causes of death, in order were: (1) Pneumonia (2) Tuberculosis and (3) Diarrhea and other acute gastro-intestinal disorders.

SAMUEL M. GILBERT, M.D.
Newark

Medical Aspects of Nonspecific Ulcerative Colitis*

In the treatment of nonspecific ulcerative colitis, psychotherapy is the major weapon. Dr. Gilbert also sees a limited role for certain specific drugs.

IDIOPATHIC or nonspecific ulcerative colitis is a serious and complex condition which taxes the skill of the attending physician. It is a disease of young people, with 75 per cent of cases occurring under 40 years of age, and 25 per cent before 20. Males and females are equally involved.

No single factor, chemical, allergic, bacterial, psychogenic or metabolic, can explain the syndrome. The disorder is most often found in the oversensitive, insecure and frustrated people. I have seen many cases in young people in homes where a mother has been lost; in fact, I know a brother and sister in one such family now suffering from the disease. In many cases there is an unhappy home life with dissension between the parents resulting in confusion, divided loyalty and insecurity. While many can adjust to such circumstances, these patients apparently have a sensitive bowel and react to adversity with attacks of diarrhea. As Grace[1] has pointed out, these patients react to sustained mental conflict with anger, resentment, and hostility resulting in intestinal hypermotility, engorgement, increased lyzozyme, and fragility of the intestinal mucosa with submucosal bleeding and erosion with ultimate development of ulceration and hemorrhage. In my experience, this pattern holds in most cases for both the onset of the illness and for its exacerbations. Once ulceration has occurred, secondary infection or spread of the disease results in more severe diarrhea with loss of minerals, vitamins, and blood. We then have a fully developed ulcerative colitis subject to more complications from toxemia, including arthritis, iritis, pyoderma, abscesses with or without fistula formation, perforations, and malignant degeneration in a fair proportion of cases where the ulcerative processes have persisted over 10 or 15 years.

THE acute fulminating case starts abruptly with severe bloody diarrhea, high temperature, and severe toxemia. The bowel emissions may be almost continuous and usually contain little stool, consisting mostly of blood, mucus, and pus. The attack may last 2 or 3 weeks and becomes worse with progressive rapid loss of weight and strength. It may suddenly subside and pass into a subacute or chronic phase.

The more common onset is insidious with a first complaint of either diarrhea, abdominal cramps and tenesmus, and/or the passage of bloody mucus in the stools. At this point proctoscopic examination will reveal a mottled, congested discoloration in the rectal mucosa with a shower of petechia under the mucosa, resulting in pin-point ulcerations. A cotton

*Read May 16, 1956 before the Gastroenterology and Proctology Section of The Medical Society of New Jersey.

swab rubbed over the mucosa will elicit an ooze. Later, the mucosa may become swollen and granular. It bleeds readily, and is covered by a pussy exudate. Still more advanced or acute cases disclose an intensely edematous mucosa covered with a gushing of pus, blood, and mucus.

It is essential to sigmoidoscope every patient who comes to the office complaining of diarrhea, especially if blood has been noted in the stool. It is at this time that much can be done for the patient.

About 95 per cent of cases of ulcerative colitis begin in the rectum. This is a region of the body easy to examine directly. Roentgen studies are of little or no value in early cases. We must rely on the procto-sigmoidoscopic examination. In the chronic cases roentgen studies will be helpful.

MANAGEMENT

WHAT shall we do with these early cases?

First, the attending physician must decide if he has the time and knowledge to treat these cases. He must take the time to outline carefully the daily routine of the patient including how much responsibility he can handle, if any; what he may eat and must not eat. The physician must also offer supportive psychotherapy to these patients. My psychiatrist colleagues assure me that deep psychotherapy is potentially harmful in these cases. The important thing is the patient's implicit confidence in the attending physician. The patient must be gently led to a feeling of greater security in himself. The doctor should gradually instill confidence that the patient can handle life's problems. He must be reassured that the disease is curable. These patients usually have good intelligence and can be reasoned with on a high intellectual level. Grace, Pinsky and Wolff[3] treated a group of 34 patients with psychotherapy emphasizing alleviation of stress in the patient's life, without giving drugs. These did far better than another group of 34 patients, equally ill, treated with special diet, antibiotics and other somatic measures.

With confidence established, I stress diet only to eliminate bowel irritants. Diet is rarely the cause of the colitis. Certain foods definitely aggravate the condition. I agree with Andresen[4] that milk is poorly tolerated in colitis. Some boiled milk is allowed, cooked with cereal only. Fruit juices, cold drinks and raw vegetables are not permitted. A high protein diet is stressed.

Codein, grains ¼, is effective for "cramps." I use a plantaga ovata concentrate commercially available as the Burton, Parsons and Company L. A. Formula®. I also use a psyllium seed-dextrose combination, registered as Metamucil® by G. D. Searle and Company. These tend to give soft stools.

Belladonna or the newer anticholinergic drugs are helpful also. There is marked sodium depletion in these cases due to extensive intestinal excretion of sodium with a tendency to retention of calcium and (to a lesser extent) of phosphorus. The intestinal excretions of anions over and above chloride, bicarbonate and phosphate, explains the sodium depletion, calcium retention and the acidity of feces and ileostomal outputs. The pH of the feces from a patient with ulcerative colitis may be as low as 5.4. I encourage the use of salt on foods and give it in tablet form and intravenously in the sicker patients. Vitamins, especially the water soluble groups, are important, preferably given in divided doses. Phenobarbital is helpful in most cases for relieving tension. Morphine or large doses of opium tend to paralyze the bowel and cause abdominal distention. Strong sedatives tend to depress the patient. Here again reassurance may obviate the need for powerful drug therapy.

CHEMOTHERAPY and antibiotics have their place in the treatment of ulcerative colitis. Every drug from sulfa in all its forms and every antibiotic has been credited by some workers as a new cure for this disease, only to be discarded as a new drug came along. Drugs alone will not cure the disease. In the early ambulatory case, with no fever, neither sulfa drugs nor antibiotics are indicated. In the patients with moderate to high temperature, I prefer chloramphenicol† orally, plus strepto-

mycin intramuscularly, for a short course in severe cases. Chloramphenicol, in my experience, does not cause the annoying diarrhea seen too often with Aureomycin®, tetracyclin and oxytetracyclin. I have used chloramphenicol† extensively and to date have not seen any of the complications of aplastic anemia described in the literature. Perhaps I have been just fortunate, but I do fear the diarrhea complications seen with the other antibiotics. Erythromycin® should be used if a staphyloccic diarrhea ensues as a complication of antibiotic therapy. Azopyrine® and Azulfidine® were introduced by Svartz [2] because of their supposed specific affinity to connective tissue lesions, but the results are no better than with other drugs.

ACTH is our newest weapon in ulcerative colitis. I have found this hormone helpful in promoting a remission in acute cases with fever. It mollifies the symptoms, gives the patient a sense of well being, and improves the nutrition possibly by its anti-inflammatory actions or its sustaining effect on bodily resistance. It is not curative. It suppresses manifestations of the disease without reversing the fundamental disease process. The chronic case is not helped in my experience. Kiefer and Elliott [3] in a study of 35 cases of ulcerative colitis (treated with ACTH for two years) found that 23 received early benefit, but that 15 had relapses. Only eight patients were well after two years. It is also important to remember to withdraw the drug gradually in order to avoid acute exacerbations. I have found ACTH more helpful than cortisone or the newer Prednisone® derivatives. Transfusions are helpful in the moderate to severe cases. The blood protein and sodium and potassium levels should be checked frequently, with deficiencies corrected promptly.

PROGNOSIS

In 75 per cent of cases of nonspecific ulcerative colitis we are able, with the above measures, to control the disease. Tendency for relapses is great. These patients must be followed carefully in an attempt to prevent recurrences. Relapses usually follow an emotional crisis, or a period of tension in the life of the patient, or lowered resistance due to an intercurrent infection. Dietary indiscretions help precipitate the relapse, but usually are not the sole cause. Repeated exacerbations result often in increased severity of the disease and in spread from the rectum to the remainder of the bowel with increasing general toxemia. It is in the resistant cases that progress to severe malnutrition, severe anemia, arthritis, multiple fistulae, strictures, repeated severe hemorrhages, cancer formation, and even perforation, that we must turn to the surgeon for help. Modern surgery has been able to rescue many of these cases for us.

SUMMARY

Nonspecific ulcerative colitis is a severe disease of young people. It may be acute or chronic, with a great tendency to relapses. Early diagnosis and adequate medical therapy will control 75 per cent of cases.

144 Clinton Avenue

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†I use the Parke-Davis brand of chloramphenicol which is trade-named Chloromycetin®.

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Milton B. Sloane, M.D.

Englewood

Recapitulation of Local Antibiotic Therapy*

Dr. Sloane here reviews the role of locally applied antibiotics. He reports that Nystatin® was vastly effective in clearing up monilial infestations.

As each new antibiotic is developed, its local application is eventually tried. Some are found to be unsuitable for parenteral or oral use, yet show a very definite value when used locally. At this time, as the tide of bacterial antibiotics appears to be quickening, a recapitulation of the clinical results of the more popular antibiotics appears to be in order. In addition, a new group of antimycotic antibiotics is beginning to take its place. These have not been completely explored but I shall discuss the use of one of these newer antibiotics. We seem to be coming to a narrowing pattern of use in our present program. Perhaps it may return to the direction of chemotherapy. Thus Horsfall[1] has discussed the possibility of using the Benzimidazole® derivatives in the chemotherapy of viral diseases. He reports on its use *in vitro* only. Time will tell whether this therapy can be adopted medically.

Among the more commonly used anti-microbic antibiotics for local application are: penicillin, bacitracin, Neomycin®, Aureomycin®, Terramycin®, Achromycin®, Erythromycin®, Chloromycetin®, Polymyxin®, Gramicidin®, and tyrothrycin. Each investigator shows minor differences in his results when testing these antibiotics; however, their results in general do agree.

Livingood, Head, and Sutor[2] compared the results of Neomycin® and other antibiotics. They concluded that Neomycin® cannot be recommended for systemic use because of its toxicity. They also felt that there appeared to be less tendency for the bacterial organisms, including pseudomonas and proteus, to develop resistance to Neomycin® in prolonged use than there is in the case of other antibiotics. Also, that Neomycin® used locally, is superior to, or is at least as effective as, any other available antibiotics for cutaneous infections due to staphylococci and gram-negative rods. They felt that bacitracin may be very effective and is very definitely the antibiotic of choice for certain other strains of hemolytic streptococci.

Experience indicates that the sensitizing potential of bacitracin, Neomycin® and chlortetracycline and oxytetracycline is low; bacitracin and Neomycin®, less than 0.5 per cent and the others, slightly higher; 0.5 to 1 per cent. Their findings are summarized in Table 1.

Miller, *et al.*,[3] concluded that "for local therapy we advocate bacitracin, Neomycin® and Polymyxin B; however, experience with chlortetracycline, oxytetracycline, and Erythromycin® shows less than 1 per cent sensitivity. Widespread use of the antibiotics locally has produced little evidence that sensitization has been a factor in preventing the use of these antibiotics when needed for internal administration. While, in general, antibiotics not intended for parenteral use should be given pref-

*Presented before the Dermatology Section of the 100th Annual Meeting, The Medical Society of New Jersey, May 16, 1956, Atlantic City.

TABLE 1.

	1	2	3	4
Hemolytic Staph. Aureus	Neomycin®	Oxytetracycline	Chlortetracycline	Bacitracin
Hemolytic Streptococci	Chlortetracycline	Oxytetracycline	Bacitracin	Neomycin®
Gram-Negative Bacilli	Neomycin®	Oxytetracycline	Chlortetracycline	
Pseudomonas	Polymyxin®			

erence, the use of oxytetracycline, chlortetracycline and Erythromycin® locally seems justified."

Sulfonamides and penicillin are locally contraindicated. There is an almost 10 per cent incidence of sensitivity produced by the sulfonamides, and a 5 to 10 per cent sensitivity to penicillin ointment. There seems to be no justification for ever using these two medications locally. Livingood, Head and Sutor[2] felt that tyrothrycin and Gramicidin® are inferior to bacitracin. They do not believe that combinations of antibiotics are more effective than the single antibiotics

Wright and Purcell,[4] say, "Like oxytetracycline (Terramycin®) and chlortetracycline (Aureomycin®), tetracycline ointment is distinguished by a high degree of toleration and paucity of toxic reactions."

Miller *et al.*,[3] also agreed that, in general, there is no advantage in using a combination of antibiotics locally; "In our studies with tyrothrycin we were unable to demonstrate any distinct advantage with a combination of bacitracin-tyrothrycin over those antibiotics used singly. The results obtained with a combination of Erythromycin® and Neomycin® are in general agreement with those found in the other antibiotics that had been used singly and no distinct advantage has been found in the combination."

Used locally, antibiotics may be attended with the following complications: (1) Sensitization, (2) Loss of effectiveness, or increased tolerance of the organism to the antibiotic and (3) The production of a localized moniliasis at the site of application. Stewart[10] found that 13 per cent of children receiving antibiotics had positive pharyngeal Candida Albicans cultures. Those taking antibiotics of the tetracycline series had the highest incidence.

The recurrent question of whether monilia albicans is a facultative pathogenic organism or merely a saprophyte has not been solved. Sulzberger and Baer[6] state that the "evidence of the facultative pathogenic role of the Candida Albicans in producing dermatoses appears as the same order as the evidence for the other dermatophytes and pyococci. We concur in the opinion of those who hold that Candida Albicans is a true facultative pathogenic organism, and is not always a purely pathogenic or purely saprophytic inhabitant of the human skin, oral or vaginal cavity." They point out that the common failure to find the monilia may be due to the fact that the monilial organism has disappeared and what remains is a moniliid.

Dobias[7] has shown that, while Candida Albicans can be isolated from apparently normal vaginal mucous membrane or stools, it is not commonly present on normal skin, nor is it commonly found in skin disorders of other etiology. Other investigators (Haler,[5] Borts, Haseltine and Plass,[9] Ludlow and Henderson[10] found Candida Albicans in a large proportion of the oral cavities of children. Dobias[7] concluded that: (1) If Candida Albicans is isolated from the skin of the child with a suspicious-looking skin disorder, it should be assumed to be the causative organism unless proved otherwise. (2) While Candida Albican may be present in the oral cavity, vagina or bowel of an infant or adult without causing clinical symptoms, it remains a potential source of infection. "Let the proper kind of physiologic disturbance occur in the host and the equilibrium be upset and the organism starts proliferating in an uncontrolled manner." (3) Maternal vaginitis seems to be one of the principal sources of contamination and probably takes place at birth. (4) "Candida Albicans probably can, for short periods, remain viable on inanimate objects or on the normal skin of the hands of mothers or nurses."

Hill[11] says: " . . . In the past five years, I

have been impressed with the increasing frequency of skin moniliasis in young infants under the age of two months. This often begins in the newborn period, around the anus and pubic area, and spreads rapidly to the neck and face . . . Some of the mothers may have oral thrush; the mothers of others have had vaginal moniliasis during pregnancy."

MANY antifungal antibiotics have been developed from the actinomycetes: The most promising of these have been Candicidin®, Endomycin® and Nystatin® from the streptomyces group of fungi, and Fungistatin® from the bacillus subtilis. More recently, Amphoteracin® (from a hitherto unknown species of streptomyces) appears to show great promise. The antifungal antibiotic which has been subjected to the most intensive clinical testing is Nystatin®, isolated from cultures of streptomyces Noursei by Hazen and Brown.[12] Despite repeated efforts on the part of laboratory investigators, no strains of resistant Candida Albicans have been produced.[13] Stewart[19] concluded that Nystatin® inhibited cell division and mycelial growth of Candida and that this effect is fairly complete at concentrations of 5.2 units per milliliter.

In my preliminary report,[14] the use of Nystatin® in 8 cases was outlined. Since that time, it has been tried much more extensively. Thus, Graham[16] has used Nystatin® to treat 94 patients with monilia albicans. These included 30 with oral moniliasis, 15 with vaginal moniliasis, and 49 with cutaneous involvement. The clinical response was in general good to excellent; lesions frequently disappeared within 72 hours. Relapses were infrequent and no resistance was noted to the drug in cases being retreated or treated for long periods of time.

Gross[15] treated several cases of intertriginous monilial infection, anal moniliasis and one of Candida Albicans infection of the penis and scrotum and also several cases of paronychia due to the same organism. He noted prompt results in almost every case and no case of primary irritation or sensitization was observed, even in cases of extensive intertrigo.

Grupper[17] reported a "cure" within 5 days of a 27-year old male with a generalized cutaneous vegetative moniliasis, using Nystatin® locally and parenterally. He also reported a "cure" in 12 cases of intertriginous moniliasis in 4 days, and a relatively rapid cure in 16 cases of paronychial moniliasis. He noted that in these latter cases, best results were obtained by using Nystatin® orally as well as locally.

Osborne[18] reported cures in 3 weeks of 3 cases of moniliasis of the skin and ano-genital areas by local applications of Nystatin.®.

Dobias[7] concluded as results of his experiences with oral, intertriginous and vaginal moniliasis in children that: (1) The concomitant use of Nystatin® ointment with oral administration appears to be the treatment of choice. (2) Treatment should be continued for several days after the complete disappearance of the symptoms. (3) The use of Nystatin® in pregnant women with vaginal moniliasis could probably prevent many cases of neonatal moniliasis.

In my present series, 73 patients were treated with topical Nystatin.® The material used was administered in the following forms: Troches, each containing 3,000 units; an ointment containing 50,000 units per Gram in Plastibase® (oleaginous ointment base); a vaginal suppository containing 30,000 units; a freshly made solution in propylene glycol containing 150,000 units per milliliter; an ointment combining Nystatin® 100,000 units per Gram with Fluorohydrocortisone.®

No attempt was made to administer the drug orally or parenterally concomitantly. No cases of the other mycoses were treated.

Results were as indicated in Table 2.

CONCLUSIONS

MY RESULTS were in general agreement with those of other investigators. The response of the monilial infections to Nystatin® was generally very rapid, especially in oral and anal infection (24 to 72 hours). In one of the cases with the lesion on the glans penis, all symptoms disappeared within 24 hours, after

TABLE 2

Location	Number of Cases	Cured	Improved	Unchanged	Irritated
Paronychia	21	10	4	7	0
Vaginal	9	5	3	1	0
Peri-Anal	8	5	2	1	0
Glans Penis	2	1	0	0	1
Intertriginous	26	15	3	3	5
E. Interdigitale Blast.	4	2	1	0	1
Oral	4	3	0	1	0
	74	41	13	13	7

previous therapy with other agents for almost three months. This same experience was noted in several of the cases of intertriginous moniliasis. Those women with vaginal moniliasis who were successfully treated showed dramatic results, with the disappearance of the burning discharge and edema in *2* to 5 days. The most resistant cases were those with paronychial infections.

Seven cases of irritation are indicated; most of these, as expected, were in the intertriginous group. In three of these (two with an intertriginous infection, and one with an infection of the glans penis), irritations were caused by *all* ointments. Five other patients (two intertriginous infections, two cases of vaginal infection and one with oral involvement) showed relapses requiring re-treatment.

The addition of Fluorocortisone® ointment appeared to aid in reducing inflammation. Thus Nystatin® appears to show definite promise in the therapy of monilial infections. As newer varieties and more stable preparations are produced, its value should increase.

500 Grand Avenue

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Cardiac Arrest

Evaluation of 5-Years' Experience at the Newark Presbyterian Hospital*

Few tragedies in the doctor's life are more poignant than the unexpected operating room death. The family doctor or the attending surgeon would rather do almost anything else than face the family at this point. Yet there has been surprisingly little study of these cardiac arrests. Here Dr. D'Alessandro and Dr. Vlatten review the problem, offer a workable classification, and suggest remedies.

Cardiac arrest, cardiac standstill or death in the operating room has plagued surgeons for many years. It was first reported in 1848 in a patient who was receiving chloroform for the removal of a toenail. Since then, much work has been done on operating room resuscitation. Today every well equipped operating room has readily available, methods to restore the patient. However, little advance has been made in determining the causes of death in the operating room and in developing methods to prevent them. This has probably been due to our failure to define and classify cardiac arrest. We tend to call all operating room deaths cardiac arrest. This term is becoming as meaningless as the waste-basket term of yesteryear, status lymphaticus. While we may know how to resuscitate cardiac standstill, recovery rates are still too low. It is necessary that this catastrophe be adequately defined and classified. Table 1 shows the reported incidence of cardiac arrest.

This great variation in incidence only

TABLE 1. REPORTED INCIDENCE OF CARDIAC ARREST

Reporter	Number of Operations per Arrest
Johnson [1]	6000
Blades [2]	5000
Ehrenhaft [3]	2840
Stephenson [4]	2348
Gerbode [5]	2035
D'Alessandro [12]	1587
Trent [6]	1424
West [7]	1200
Sadove [8]	1000
Miller [9]	857
LeBrigand [10]	557
Cooley [11]	18

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means one thing: that cardiac arrest needs more specific definition so that we can be sure we are all talking about the same thing. Some feel that the incidence has increased. Many patients are being taken to the operating room who were considered inoperable years ago. With the advances made in anesthesia, more radical surgical procedures have been possible. Consider, for example the increased scope of surgery in the last ten years in respect to thoracic surgery, cardiac surgery and malignant diseases. Procedures such as bronchoscopies are now often done under general anesthesia rather than local. Perhaps because of the advances in anesthesia, the scope of surgery has gone beyond the tolerance of the patient.

All patients who die in the operating room should be considered as having had operating room deaths. The term "cardiac arrest" should be discarded or reserved for special groups. We group all our operating room deaths under two general terms: (1) primary cardiac arrest and (2) secondary cardiac arrest. See Table 2.

TABLE 2. CLASSIFICATION OF OPERATING ROOM DEATHS

1. Primary or true cardiac arrest
2. Secondary or delayed cardiac arrest
   (a) Cardiac disorder
   (b) Respiratory disorder
   (c) Circulatory disorder
   (d) Metabolic disorder

Primary, or true cardiac arrest, should be restricted to the sudden lack of blood pressure, pulse and respiration. Secondary cardiac arrest should be limited to a progressive state which terminates in stoppage of the heart. With these two general terms and definition, we have devised the above classification.

A review was made of 30,000 surgical procedures performed during a five-year period. In every operating room death, an attempt was made to identify the actual cause according to our classification. There were 19 operating room deaths during this period for an incidence of 1 to 1587 surgical procedures. See Table 3.

TABLE 3. RESUSCITATION AND SURVIVAL RATES

	Cardiac Arrests	Resuscitated	Survival	Percentage
Primary arrest	5	3	1	33
Secondary arrest	14	10	1	10
a. Cardiac	6	5	0	0
b. Respiratory	2	1	0	0
c. Circulatory	4	3	1	33
d. Metabolic	2	1	0	0
	19	13	2	15

Of the 19 operating room deaths, five were classified as primary and fourteen as secondary. Thirteen patients were resuscitated by thoracotomy and 6 were not. Three had primary cardiac arrest and ten had secondary cardiac arrest. One out of the three primary cardiac arrests was successfully resuscitated. One out of ten secondary cardiac arrests was successfully resuscitated. Thus, chances of survival are greater with primary cardiac arrest.

There were eleven cardiac standstills and two ventricular fibrillations among the thirteen who had a thoracotomy. A heart response that lasted for at least one hour occurred in eleven out of the thirteen patients.

Two of our patients have survived with no complications. The other patients whose hearts responded to treatment lasted thirteen days, five days, thirty hours. The other 6 lasted one to seven hours.

The types of operations were varied and were not significant. See Table 4.

TABLE 4. OPERATIONS IN WHICH CARDIAC ARREST OCCURRED

3 Lumbar or thoraco-lumbar sympathectomies
2 Hysterectomies
3 Intestinal obstruction, bowel resection or colostomy
1 Radical dissection of the neck
1 Removal of carcinomatous bladder
1 Evisceration, repair of
1 Esophagoscopy
1 Jaw resection
1 Laryngectomy
1 Pulmonary lobectomy
1 Splenectomy
1 Gastrectomy
1 Removal of lipoma from back

Patient risk was divided into "poor" and "not poor." The 5 primary cardiac arrests fell in the "not poor" group while 12 of the 14 secondary cardiac arrests fell in the poor risk group. See Table 5. And, as reflected in Table 6, age did not seem to be significant.

TABLE 5. PATIENT RISK

	Poor Risk	Not Poor	Total
Primary cardiac arrest	0	5	5
Secondary cardiac arrest	12	2	14
	12	7	19

TABLE 6. AGE GROUP

Age Bracket	Primary Arrest	Secondary Arrest
10 to 19	1	0
20 to 29	0	1
30 to 39	0	3
40 to 49	1	4
50 to 59	0	3
60 to 69	3	1
70 to 79	0	2
	5	14

Secondary cardiac arrest occurred most frequently during the operation. Primary cardiac arrest was distributed among the time of induction, during surgery and at the end of the procedure. See Table 7.

TABLE 7. TIME OF CARDIAC ARREST

	Primary Cardiac Arrest	Secondary Cardiac Arrest	Total Cardiac Arrest
During induction	2	2	4
During operation	1	10	11
At end of procedure	2	2	4
	5	14	19

The types of anesthesia included all modern agents and technics. However, a greater proportion of patients received gas-oxygen-ether than any other agents. In the group of 19 operating room deaths, eleven patients received thiopental† sodium while eight did not. This is not significant since 80 per cent or more of the total number of cases received a thiopental† induction. Three of the 19 patients received succinyl choline†. This, too, is not statistically significant since 40 per cent of all these patients had received one of the muscle relaxants. See Table 8.

TABLE 8. ANESTHETIC AGENTS USED

8 patients—thiopental,* gas-oxygen-ether

3 patients—thiopental,* gas-oxygen-ether, succinyl choline*

1 patient —tribrom ethanol,* gas-oxygen-ether

6 patients—gas—oxygen—ether

1 patient —cyclopropane

*Succinyl choline in the form of Anectine® (Burroughs Wellcome). Tribrom ethanol in the form of Avertin® (Winthrop-Stearns). Thiopental as Pentothal® (Abbott).

To learn more about the mechanism of this emergency, we have been using the operating room cardioscope. This makes it possible to operate with greater safety on poor risk patients and perhaps may be able to warn us of oncoming disaster. It gives you a continuous evaluation of the cardiac status of the patient. The cardioscope has been of great assistance in our poor risk patients and in difficult and long procedures. It is of great value in the old and debilitated patients whose hearts may not tolerate a great deal.

Disturbances in cardiac rhythm are frequent during general anesthesia. We studied more than 500 electrographic tracings of patients during surgical procedures. It was observed that many arrhythmias occurred with all of the commonly used agents. Many times the anesthesiologist is unable to pick up the irregularities in the peripheral pulse which show up on the electrocardiogram. In these patients, there may be great variation between the palpable pulse rate and the electrocardiographic calculated heart rate. The latter is usually faster.

†These drugs are more commonly identified by their registered trade names. Thiopental is usually given under the Abbott trade-name of Pentothal® and succinyl choline under the Burroughs Wellcome trade-name of Anectine.®

The first arrest in this series occurred in an 18-year old girl during esophagoscopy. It was primary or true cardiac arrest produced by reflex stimulation. It occurred during the early period of our study before thoracotomy and cardiac massage was standard procedure. This patient did not survive.

Another primary cardiac arrest was in a 66-year old man, admitted for removal of a lipoma of the back under thiopental†-gas-oxygen-ether. While in the lateral position, and at the time of the incision, there was sudden absence of pulse, blood pressure and respiration. Thoracotomy was quickly performed and cardiac massage instituted. The patient was oxygenated. With a few massages, spontaneous heart action returned. The patient was discharged seven days later after an uneventful postoperative course.

A secondary cardiac arrest was in a 57-year old man admitted with arterial insufficiency of the left leg, arteriosclerosis and diabetes. Electrocardiogram showed old posterior wall infarction, left bundle branch block and coronary insufficiency. He came to the operating room for a lumbar sympathectomy. After a thiopental†-gas-oxygen-ether sequence, the patient was in a lateral jackknife position. Blood pressure gradually dropped. It continued to fall in spite of vasoconstrictors until the heart stopped. From the last beat to the time of cardiac massage, was less than two minutes. The heart response was slow but in fifteen minutes was adequate and spontaneous. After an uneventful postoperative course, he was discharged ten days later. Five weeks later, he returned with arteriosclerotic gangrene of the other foot. He was again scheduled for lumbar sympathectomy. The same anesthesia technic was used. The patient tolerated the procedure well. After anesthesia had been discontinued for five minutes and the dressing was being applied, a progressive fall of blood pressure occurred and the heart stopped. Immediate thoracotomy and cardiac massage was instituted. The heart responded spontaneously after 21 minutes of massage. General condition was termed fair and he was returned to his room. Six hours later patient was pronounced dead without regaining consciousness.

A 73-year old man developed secondary cardiac arrest due to circulatory disturbance. Thoracotomy and cardiac massage were instituted. During the massage, the myocardium was perforated three times and sutured. Resuscitation was unsuccessful. Since that time, Dr. Edward Sprague has suggested that if the pericardium is opened in order to inject drugs or apply electrode for defibrillation, it should be re-approximated when massage is performed. In this manner, the pericardium will act as a protection against perforation of the heart during massage.

A 23-year old woman was admitted for splenectomy. She had been repeatedly hospitalized for transfusions. During two days preceding surgery, she received 1½ liters of blood. Hemoglobin increased from 50 to 87 per cent. Under thiopental†-ether-succinyl choline,† splencetomy was done. The procedure was technically difficult. She suffered a sudden short period of considerable hemorrhage while the splenic pedicle was being dissected. During this period of shock and anoxia, endobronchial suction was necessary. Her condition rapidly deteriorated to cardiac arrest. Thoracotomy and massage were done. After ten minutes of massage, spontaneous heart action returned. Ventricular tachycardia developed. Procaine amide hydrochloride* was given and this converted the condition to supraventricular tachycardia. Digitalization was begun with Cedilanid®. Cardiac action gradually improved. Temperature rose to 104.8 and was reduced to 99.6 with ice packs. Six hours later, she was returned to her room. Tracheotomy was done. On the first day after the cardiac arrest, blood pressure was 120/80 and pulse was 144. She had spasticity of both legs. The Babinski was positive on both feet. She was unconscious. Her electrocardiogram remained normal but she never regained consciousness. She died after a slow downhill course, thirteen days after the secondary cardiac arrest due to circulatory disorder.

SUMMARY

1. A review has been presented of 19 operating room deaths which have occurred during 30,000 surgical procedures. This is an incidence of 1 to 1587.

2. The term "cardiac arrest" should not be used unless it is defined. A classification has been presented in which operating room deaths are divided into primary and secondary cardiac arrests. Primary cardiac arrest is the sudden absence of blood pressure, pulse and respiration. Secondary cardiac arrest is a progressive deterioration of the patient's condition with the ultimate absence of blood pressure, pulse and respiration.

3. There were 5 primary or true cardiac arrests for an incidence of 1 in 6000 and 14 secondary cardiac arrests. One out of the three primary cardiac arrests resuscitated survived. There was also one survival of the ten secondary cardiac arrests resuscitated.

4. Type of operation did not seem to be significant. Primary cardiac arrest occurred in patients not considered poor risks. Secondary cardiac arrest occurred mostly in the poor risk patients.

*Procaine amide hydrochloride was given under the Squibb trade-name of Pronestyl®.

5. Age groups showed no significant correlation with incidence of cardiac arrest. Death was most prevalent during the period of surgery for secondary cardiac arrest, while primary cardiac arrest was equally distributed among induction, surgical period and end of procedure.

6. The type of anesthesia with which most deaths occurred was thiopental†-gas-oxygen-ether. Since this was used in over 80 per cent of the total cases, these figures are not significant.

7. Colored females and white males seemed more prone to operating room deaths than the others.

8. The cardioscope has been helpful in preventing some operating room deaths.

CONCLUSIONS

GREATER efforts should be made toward the prevention of cardiac arrest in the operating room. If our patients can be better prepared for surgery; if adequate time is allowed for the proper induction of anesthesia in the poor risk patients, if we can classify these deaths more accurately, then perhaps our aims to reduce operating room deaths to a minimum may be realized.

27 South Ninth Street

Women in Medicine

The first woman physician in this country entered medicine because she was shy of men and didn't want to marry. It was 100 years ago when Dr. Elizabeth Blackwell became the first woman to practice medicine in the U. S. Women have learned a lot since then — about both men and medicine.

The 1954 graduating class of the Woman's Medical College of Pennsylvania (the only medical school in the country which doesn't admit men) even included a grandmother.

And at the coeducational medical schools it's the same story but with an important difference. There the women may carry off top honors from their male classmates.

At the Tennessee College of Medicine, for instance, Dr. Ray Schwarb Greenberg, led her classes for all four years. She had spent 3 and one-half years at Barnard college studying economics.

Another award winner overcame infantile paralysis—which left her with a shortened left leg—to become a college basketball player, lifesaving and swimming instructor, and top scholar for all four years in a class of 100. She is Dr. Mary Lou Hoover, Timberville, Va. of the Medical College of Virginia at Richmond. After internship in Colorado she will enter a rugged life as a rural Virginia doctor.

One of the two Drs. Usher entering internship at Philadelphia hospital is a blond who won the award for excellence in French at McGill University — Dr. Martha Wells Usher. At McGill she met the other Dr. Usher, her husband Robert, from Montreal. Martha was number one in a class of 153 at Michigan. Only 5 per cent of her classmates were women. The "weaker half" of the Usher medical team plans to enter pediatrics after they finish their internship together. She is from Ann Arbor, Mich.

Dr. Katharine Emory Spreng, Cleveland, Ohio, followed her parents' footsteps at Western Reserve University School of Medicine. Her parents are Dwight S. Spreng, M.D., and Elizabeth Dial Spreng, M.D. Dr. Richard H. Young, dean of Northwestern University Medical School, predicted a brilliant future for Dr. Ethel Frances Young (no relation), of Chicago, who led her classes for the first three years and graduated in first place.

A radio and radar technician for the Army Signal Corps became the first woman in the history of the Medical College of Alabama to graduate in first place. Dr. Jean Cowsert, one of only two women in her class of 60, was a straight A student. And the Mobile girl captured both of the two prizes open to freshmen— in anatomy and biochemistry.

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Progress in Psychiatry*

The number one health problem of the world is mental disease. If there is any hope of conquering that problem, that hope lies in research. Yet only a tiny amount of money and manpower is devoted to psychiatric research. More is spent in studying the habits of Hessian flies than in doing research on the human mind. Some of the magnificent possibilities of such research are here hinted at in this challenging paper.

The present cross section of psychiatric work reveals at least five current trends: (1) emphasis on the early recognition, management and care of persons affected with mental disorder; (2) new methods of treatment with the assertion of an increased rate of discharge of patients from mental hospitals; (3) accelerated swing of research interests into pharmacologic, neurophysiologic and neurochemical channels; (4) attraction of more adequately prepared, promising young scientific workers into this field and (5) mobilization of more liberal financial support for psychiatric research (as for instance, from the federal government, the Council of State Governments and the Ford Foundation).

Someone has said that "research is the systematic penetration towards new levels of ignorance." This is true in the sense that every successful search reveals new and unexplored areas and problems. However, there are always two principal goals toward which we work and aim with whatever tools are available. One is to discover etiologic factors and thus allow a direct attack on prevention and cure of the psychoses. The other is to determine, and then reinforce, the capacity of people to stand the mental stress inherent in living. How can we raise the threshold that constitutes the difference between the normally adjusted and the maladjusted? I suppose this is what is meant by "mental hygiene" or prevention.

In pursuit of these general goals there are "frontiers of research" in which workers are attempting some expansion of knowledge. These may be listed as (1) hereditary and other constitutional factors (2) neurochemistry and allied biochemistry (3) neurophysiology (4) experimental psychiatry including experimental therapy (5) experimental psychology (6) experimental psychotherapy and (7) social psychiatry. Some of these areas focus on fundamental problems related to behavior functions such as those in chemistry and physiology. Others center on the forms of social structure most likely to yield information on ways to improve mental quality and strength and to reduce the incidence of addictions, juvenile delinquencies and crimes in general.

To point up briefly the complexity of the situation under consideration: where matter and energy are integrated into an entity called "life" there is something produced with six

*Read at the 190th Annual Meeting of The Medical Society of New Jersey, Atlantic City, May 16, 1956.

involved properties (and they all concern us). They are evolution, inheritance, reproduction, variation of characters, metabolism, and mind phenomena. The normal operation of these in the individual, when obstructed or deviated, result in constitutional inferiorities. Such inferiorities appear in one or more of four categories: (1) In the bodily morphology, physiology or biochemistry (metabolism), (2) in intelligence capacity, (3) in emotional capacity and (4) in ethical sense. These compose the constitutional pathology or *grund patholigie* of the texts. Involving the mental disorder issue are also the other pathologies; the organismal, the pathology created by social forces and the pathology possibly if not probably created by cosmic forces.

THE most important step in the progress of any science is the measurement of quantities by instruments of precision. If anything, any phenomenon exists at all, it is present in some quantity. When it is impossible to measure the quantity, the right technic has not been found. The diagnosis and treatment of psychiatric disorders rely largely on methods which lack precision. Just as the noise in the stethoscope used to mean different things to different listeners in the early days of that instrument, so mental symptoms seem to mean different things to different psychiatrists. This lack of precision accounts for the extreme variations and contentions over the diagnostic "labeling" of cases of mental disorder, a confusion that has damaged research on groups of patients no end. Much of it will have to be done over later when there is some consensus on the criteria. In the meantime, we must explore psychiatry to the limit with what methods we have while awaiting a suitable advance in basic science. Moreover, one might be reminded that it is not absolutely necessary that the ideas one works with should be quantitative ones, for example most of Sherrington's terms were not quantitative but their influence on neurologic thinking has been profound over many years.

Genetics deals with, perhaps, the most basic elements as it is at the "front end" of cause and effect. It provides hard facts when the data are available. For example, the basic cause of Huntington's chorea was once obscure. Genetics pulled it out of the psychiatric hash and identified it as a distinct condition, etiologically and clinically. An obstacle to advance in many of our problems is that the so-called "facts" are capable of being twisted in several directions. The application of genetics scientifically is quite difficult in the field of psychiatry, but several workers are investigating with some success.

It is easier to apply in animal behavior research where one can frequently show how hereditary factors fit into other elements of a pathoplastic nature. For example, "The interrelationships of hormonal, hereditary and early life experience factors in an instinctual pattern of behavior have been studied in Dr. William C. Young's laboratory at the University of Kansas. Valenstein[1] showed that male sexual behavior required the presence of the male hormone. The degree of activity was independent of the amount of hormone above the minimal requirement. This was determined by hereditary factors. In addition, "adult male sexual behavior did not appear in animals isolated from their mother and siblings from an early age, although the age at which isolation had this effect varied with different strains and was therefore hereditarily determined." (Quoted from Rioch.[2]) This work was done in guinea pigs. One should not translate such findings into human behavior forthwith. But it is probable that basic biologic laws are similar to a considerable degree throughout living organisms.

Perhaps the most significant results in the psychiatric program have been realized in the studies on growth and development in childhood where schizophrenia makes its early appearance. In this field a number of significant changes in methodology have been developed. Workers in genetics are interested in constitutional factors. Here the parents and also often the grandparents are available for investigation as are the home and other environmental settings and conditions which may contribute to or combine with constitutional predisposition in producing the breakdown.

Some believe that what is inherited is not

the disease but only the constitutional predisposition. The disorder would then be produced when the predisposed individual has to deal with specific environmental stresses. Studies of the stresses are under way and may lead to preventive possibilities. It is hoped that these sick children who are increasing in number can be thoroughly investigated by biochemical methods in centers with the facilities to apply them.

One of the basic questions is that of the chemical composition of the brain. How do the brains of psychotic persons compare with the normal and among themselves chemically? Some new methods such as chromatography may be helpful. Biochemists are now interested in this much neglected field. Attempts are being made to learn the activity of the enzymes and the concentrations of other substances in the principal anatomic divisions of the brain and also in the microscopic regions of the nuclei and different cellular layers of the cortex. There is now evidence of biochemical brain changes in some types of senility and epilepsy. In time, such studies will include a variety of mental disorders.

The chemical study of brains as well as other organs from the feebleminded where there is a definite constitutional intellectual deficiency should be fruitful. At the last AAAS meeting there was a report suggesting that a low vitamin A absorption in children may produce mongolism. According to biochemical studies of the blood by Sobel,[6] a deficiency in animals causes a disproportionately slow growth of the cranium in relation to the brain. There is a definitely impaired absorption of vitamin A (administered in oil) to mongoloids compared with normal children in the same age group. Mongoloids also have high gamma globulin, low albumen and low serum calcium. Out of such a finding three research extensions were mentioned: (1) the testing of newly born mongoloids to determine if vitamin A treatment can improve their condition. (2) Mothers of mongoloids will be studied to obtain any clues of vitamin A transference to the unborn child. (3) Pregnant women will be tested to determine their blood vitamin A content. I would suggest that the mongoloid metabolic differences be compared also with children affected with other forms of mental deficiency in the search for specific causes since many metabolic differences may well be due to, rather than the cause of the mental retardation.

TULANE University workers have reported the discovery of chemical substances in the blood of schizophrenic patients which produce symptoms of the disorder. This is a protein substance isolated from the blood of the patient and injected into healthy inmates of a state prison. One developed a projection type of symptoms accusing others of persecuting him and another developed catatonia. In both prisoners the effect lasted only an hour or two.

Here one must ask: Is this substance the *cause* in terms of heredity or other "upset" body chemistry? Or is it the result of some original schizophrenic process? Is it a predisposition product or a pathoplastic one? Such questions constantly complicate research.

Experimental psychoses have been produced in many centers with lysergic acid, mescaline derivatives and other hallucinogens constituting a rich field for study of schizophrenic-like states. These studies may reveal clues to the origin of some of the spontaneously developed symptom syndromes.

A modern widespread intensive attack on mental disorder is being made with drugs which somehow calm disturbed patients—the so-called tranquilizing drugs of which chlorpromazine, reserpine, Frenquel®, Meratran®, Miltown® and acetylcholine are examples to name only a few that are now available for therapy or are under clinical trials. Thousands of patients with emotional disorders, hypertension and other conditions with anxiety components are being treated inside and outside the mental hospitals. In some centers, these drugs have practically replaced psychosurgery and the shock therapies. Many patients are discharged from the hospital and continue to take the medicine at home. Only consistent follow-up work on the ever increasing number of discharged patients will settle the question of the degree and permanence of the therapy and in

what types it is successful or fails. At any rate, it is a major activity in mental medicine. It is empirical and palliative, and so far has not contributed to the causes of mental disorders.

If the causes of mental disorders are in our social order itself as many think and advocate, then a change should be made from the brilliant conversational or oratorical approach so prevalent at present to one of rigorous critical experiment and analysis in the social sciences. Too many workers in this field seem to find answers to complicated problems by constructing one hypothesis upon a former hypothesis and accepting the "concept" as fact. One should find facts and work on them rather than limit the search in favor of some hypothesis.

We must have a unified science of human behavior by means of which such areas as (1) comparative studies of different cultures, (2) the structure and function of groups, (3) the problems of communication of ideas, policies and values, (4) leadership and (5) the growth and development of the individual can be investigated consistently according to the scientific method. Perhaps we need another Darwin who will collect and coordinate the masses of scattered psychological knowledge in a way that it can be integrated intellectually.

Ants have a fairly complex society organization with each individual having about 250 cells of nervous significance. But the single human brain contains some 10 billions of such cells; that is, about four times more than the total population of the earth. From this comparison think how complex our society must be!

Freud's original ambition was to advance knowledge of the mind in terms of the following form of progression: Anatomy of the brain to Physiology of the brain to Psychopathology to Philosophy. Perhaps this can be done one day far in the future, but at present psychic processes must be expressed in the language of psychology. To attempt to translate physiology into psychology or *vice versa* will reveal a great deal of ignorance. Cybernetics is a modern attempt to explain mind in terms of its physical basis. It may eventually approach success; now we must still wait.

Against the background of so many thousands of cases of mental illness the amount of research work bearing on the problem seems oddly inadequate. The spectacular discoveries and therapeutic advances in the management of other diseases such as diphtheria antitoxin, typhoid antigens, antibiotics, poliomyelitis vaccine, yellow fever control and so on, have been made possible by patient concentrated research, backed by adequate funds, by adequate numbers of trained investigators, and free opportunities for the exchange of ideas through the media of conferences, scientific meetings and frequent visits to other research centers.

Whether one thinks in terms of time, money, or in terms of human suffering prevented, there cannot be the slightest doubt that nothing in the long run pays such rich dividends as research regardless of the type of humanitarian field in which it finds a focus.

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The Medical Case History in the Courtroom

The doctor is sometimes puzzled by the fact that his medical history is excluded from court testimony. One third of diagnosis is based on history, one third is based on complaints, and only one third on objective findings. Yet, generally speaking, courts exclude the first two components and expect you to make a diagnosis solely on objective findings—unless you are the treating physician. Then you may put the history and subjective symptoms into the record. If you are not a bona fide therapist, you may not report the history or the patient's complaints. They are introduced by way of the hypothetical question — which is another story. Mr. Miles, a member of the New Jersey bar, here discusses the first part of this problem.

A COMPLETE case history of the patient seeking legal redress for his injuries is a *sine qua non* for an intelligent clinical picture. An examination of numerous histories reveals an overzealousness on the physician's part, inspired perhaps by Sherlock Holmes, to probe into recesses considered "out of bounds" to the medical profession. These prohibited areas concern themselves with the lawyer's domain, the liability for the injuries sustained.

It is sufficient for the physician to record, for example, that the injuries resulted from a "whiplash" to the cervical spine sustained in an automobile collision. It is improper and unnecessary to the medical picture to add such details as, "the other vehicle having proceeded through a red traffic light" or to mention the inebriety of, or alleged admissions of liability by the other driver. And any amateur sleuthing by the examining physician in an attempt to exculpate his patient from legal liability will be exposed on the witness stand. Then the taint of bias will discredit his entire testimony.

The courts, in their ceaseless search for the truth, have established certain fundamental principles limiting the scope of the physician's testimony about the patient's medical history. The wisdom of these limitations is illustrated by cases like this.

X was involved in a tavern brawl from which he emerged with head injuries. He lives in a furnished rooming house which, despite a defective common stairway, is properly covered with liability insurance. Endowed with the distilled knowledge acquired in those stimulating forums of erudition, X misinforms his doctor that his injuries were incurred in a fall down the insured stairway. Shortly thereafter the patient succumbs from a coronary embolism, the development and course of which are attributed to the antecedent trauma.

At the trial against the landlord, the doctor reads his case history and recites the fall down the stairway as the apparent cause. The fictitious "cause" of the injuries is now clothed with all the prestige, integrity and credibility of the physician. In the absence of any incisive and truth-penetrating cross-examination, the impression upon the jurors is obvious. They speedily accomplish a miscarriage of justice by returning a verdict for the plaintiff.

To avoid this result, the law does not permit the doctor to testify concerning the state-

ments of the patient as to the cause of the injury or condition. Of course, the doctor can always give his opinion, when asked, whether a fall or other event *could have* produced the injuries and resultant death of the patient. A response to a hypothetical question is much different from incorporating the facts relating the cause of the injuries as part of the doctor's report inasmuch as the items which form the hypothetical question must be proved before the hypothesis can be posed.

THE TREATING PHYSICIAN

A PATIENT may properly give the doctor a history of his physical conditions, symptoms, sensations, feelings and complaints *if* the doctor is the treating physician. Although these statements are hearsay, they may be read to the jury. They derive a measure of credibility from the theory that the patient who expects *treatment* has an incentive beyond the ordinary obligation to tell the truth.* But this incentive naturally does not extend to the legal cause or responsibility for the condition where knowledge of the cause, in cases of trauma, is not necessary for treatment.[1]

Where, however, the cause is so inextricably linked with the injuries, as in cases of industrial disease, poisoning, or mental disorders, a narration is proper and should be admitted.

PLAINTIFF'S PHYSICIAN

WHERE the plaintiff calls an expert to testify in court, it is improper for the physician to testify concerning the patient's history, his symptoms or complaints. The expert is not expected to administer treatment for the injuries. Hence, the theory runs, the incentive for truth on the patient's part is removed and the opportunities for fabricating evidence solely for the purpose of trial is too tempting.

The examining physician cannot testify as to statements of pain and suffering made by the patient for they are considered self-serving declarations, *i.e.*, made for the purpose of gain and, therefore, inadmissible. Where complaints of pain are made in apparent response to manipulation of the person, then they are admissible by the examining physician or any person in whose presence they are uttered. They are regarded in this light as "manifestations" of pain and, therefore, as admissible as the objective responses to the reflex hammer.

DEFENDANT'S PHYSICIAN

WHERE the plaintiff is being examined by the defendant's expert physician, the patient's history may be admissible. The theory is that if the statements are detrimental to the defendant's case they will not be offered. If they are favorable, they can be considered as any admission against interest which plaintiff has made to any person. For example, where upon examination the patient denies any prior history of trauma to the abdomen but the proof is to the contrary.

THE APPLICABLE LAW

THERE is an apparent conflict among the authorities as to the application of these rules. It is wise for the physician, about to testify, to consult a trial attorney for the rule in his jurisdiction.

Generally speaking, if the case history is necessary to the physician in order properly to evaluate and analyze the injuries sustained, the insistence on its admissibility should be resolute, by either the treating or examining physician.

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*"This is based on the ingenuous theory that when a patient goes to a doctor for *treatment*, he will give a truthful history to avoid getting the wrong treatment. On the other hand when he goes to a specialist primarily to enlist his support in litigation, he might exaggerate symptoms to bolster his case." Davidson, Henry A. *Forensic Psychiatry*. Ronald Press, New York 1952. Page 264.

1. This somewhat obscure statement may be clarified by an example. If you have a patient whose symptoms suggest lead poisoning, you have to know whether he was exposed to lead in his work. Thus, for purely medical reasons, you have a legitimate interest in knowing something of possible legal background. On the other hand, if you are treating a person with fractured skull, it is of no medical importance to know whether A or B was driving the car, whether the driver was drunk or sober, and whether the car had the right of way. In this case, the legal facts are not necessary for treatment, and the patient has, therefore, less incentive to tell the truth —Editor.

10 Commerce Court

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Cancer of the Larynx*

Cancer of the larynx seems to be on the increase. Dr. Vanfraenkel suggests that better surveillance of so-called "benign" laryngeal lesions may slow down the progressive incidence of this form of carcinoma. He also discusses here the pros and cons of the various types of surgical relief.

Cancer of the larynx accounts for approximately three out of every one hundred cancer deaths. A study[4] in ten American cities for the years 1937 to 1947 indicated a laryngeal cancer increase of about 75 per cent. For the period 1930 to 1948 the death rate from this disease increased 29 per cent. Present indications are that this situation is a progressive one.

Twenty years ago Jackson[9] stated that carcinoma rarely developed in a previously normal larynx. That observation is still valid. Prophylactic surveillance and judicious treatment of benign and pre-malignant laryngeal lesions should be the second line of defense until the basic, intrinsic, and biochemical cause of neoplasia is clarified. When canceration is present, its probable mode of spread should be anticipated and the most aggressive plan of attack formulated. This problem is currently being reviewed in the laboratory.

Any benign appearing lesion should be screened and biopsied until that larynx appears within normal limits and quiescent. Yale University[2] reported that in a series of 260 cases of proved laryngeal carcinoma, 14 per cent were initially diagnosed as benign. Histologic findings ranged from hemangioma, benign polyp, papilloma, keratosis, and chronic inflammation. This experience has been noted by other clinicians. Laryngeal carcinoma has also been associated with such laryngeal pathology as tuberculosis,[3] syphilis, laryngocele,[4] and aberrant thyroid tissue.[5] The clinical appearance of carcinoma *in situ* may be similar to chronic laryngitis.

Factors suspected in the development of laryngeal cancer are tobacco, alcohol, nutritional deficiency, voice strain, poor oral hygiene, deviated septum, postnasal discharge, industrial dusts and volatile by-products. Plummer-Vinson syndrome (sideropenic dysphagia) has been described[6] as an etiologic agent in post cricoid carcinoma in Swedish women. Race may play a part. *Laryngeal carcinoma has never been reported in the Eskimo* and it is uncommon in the Negro.[7] The disease occurs most frequently during the degenerative years but it may strike at any age. Like malignancy of the oral cavity it strikes the male about ten times more often than the female.

Carcinoma of the larynx may manifest itself by hoarseness, pain, dysphagia, or fits of coughing. The cough may be a dry hack or associated with eating. Throat consciousness, extra mucus, or offensive odor to the breath

*Read by invitation on May 16, 1956 to the Otolaryngology Section of The Medical Society of New Jersey at its 190th Annual Meeting.

may be significant. Unfortunately, many small carcinomas offer no symptoms. In some extrinsic lesions the "lump in the neck" is the only presenting complaint. Although pain may persist for 2 or 3 months, the emotional shock of persistent hoarseness will usually send the patient to his physician within 5 or 6 weeks. Studies indicate, however, that there is an average final diagnostic delay of 6 to 10 months.

CAREFUL examination of the head and neck and medical evaluation of the entire person is mandatory prior to treatment. Aspiration biopsy of asymmetric cervical nodes will often render valuable information if a pathologist trained in this technic is available. Lateral x-rays of the neck and laryngeal planograms may aid in determining the extent of involvement. Complete examination may reveal multiple primary carcinomas involving the larynx and other areas such as the skin, lip, tongue, pharynx, esophagus, stomach, intestine, and lung. Multiple carcinomas may occur in about 4 per cent of the general population[8] whereas in patients with laryngeal involvement, multiple primary carcinomas may occur in as high as 10 per cent.[9] This clinical entity is based on each tumor being microscopically different and on the exclusion of metastatic relationship. I have myself encountered three cases of multiple primary carcinoma of the skin and intrinsic larynx. Ages of these men ranged between 48 and 62 years. The skin lesions comprised a basal cell carcinoma of the lower lid, a squamous cell carcinoma of the scalp, and a squamous cell carcinoma of the external ear.

When early carcinoma exists limited to the anterior two-thirds of a movable cord, a classical laryngofissure is the treatment of choice. Should this tumor extend to the ventricle or 4 millimeters infrachordally, surgery may be expanded to the partial laryngectomy with removal of the underlying cartilage. At least one centimeter of normal tissue should be removed with the tumor. If the anterior commissure is superficially involved, you should resect the anterior portion of the involved cord or cords and a wedge of that portion of overlying thyroid ala.

Hemilaryngectomy may be done in selected cases where it appears that the lesion is confined to one half of the larynx and if the principle of complete surgical eradication is still applicable. Complete hemilaryngectomy has its greatest usefulness for those who are not psychologically prepared to accept total laryngectomy. Interestingly enough hemilaryngectomy reached its greatest popularity in France and other Latin countries where apparently the loss of vocal expression entails a greater sacrifice. Hemilaryngectomy is technically more difficult and effects a somewhat greater recurrence risk than total laryngectomy. Any bordering mucosa is mobilized and is advanced into the defect. A skin graft and core mold or skin flap complete the procedure. Convalescence is longer than in complete laryngectomy. The hemilaryngectomized patient must also re-educate his swallowing habits and until this is accomplished the hazard of aspiration is ever-present.

Laryngectomy is performed for extrinsic, subglottic, and extensive endolaryngeal lesions. Cord fixation usually indicates an advanced process. The modern laryngectomy is a wide field block dissection of the larynx and its appendages, including the hyoid bone. During the procedure, nodes are carefully palpated and should metastases be suspicioned a combined neck dissection is performed. For subglottic lesions the pre-laryngeal thyroid tissue should be removed with the specimen.

THE specific indications for the combined operation (laryngectomy and a radical neck dissection) are (a) a resectable lesion of the intrinsic or extrinsic larynx with palpable cervical lymph nodes; and (b) any extensive infiltrating or ulcerating extrinsic, intrinsic, or subglottic lesions without palpable nodes. The problem of impalpable metastases in these lesions has focused attention on the elective neck dissection. Fixed nodes on external examination may be misleading and during surgery one may find that the involved nodes may be dissected off the great vessels. Likewise, bulky

lesions may be irradiated initially to diminish their size and enhance their surgical removal.

Palliative laryngectomy also has its place in the treatment of carcinomatous encroachment of the air and food passages. Death due to unchecked cancer is pitiful when coupled with sloughing, necrotic, painful and ulcerating lesions. Laryngectomy, if performed, should be combined with a neck dissection to offer a curative possibility. Tumor characteristics and individual host response to tumor at times vary so greatly that it is impossible to know at what stage in its development a tumor may give rise to metastases. For advanced lesions the patient's only hope is surgical removal whenever possible and he must be given that chance.

SUMMARY AND CONCLUSIONS

1. The laryngeal cancer rate is increasing.
2. This increase can be combatted by:

(a) Routine surveillance of the so-called benign laryngeal lesions and by
(b) Routine and more widespread use of the laryngeal mirror for all vague complaints referrable to the throat and upper respiratory tract.

3. Surgical applications have been briefly discussed.

4. Three cases of multiple primary carcinoma involving skin and intrinsic larynx have been enumerated. The importance of the complete examination is therefore emphasized.

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Arthritis and Injury

D. C. Durman (J. Michigan M. S. 54:301, 1955) asks whether arthritis may be produced or aggravated by joint injury. He is surprised that so many physicians answer "yes." He states that joint injury may produce degenerative changes which gradually increase in severity with function but believes that one should not jump to the conclusion that every injury is responsible for degenerative arthritis which may develop later. For an injury to relate to arthritis it must be sufficiently severe to produce permanent impairment of the circulation to subchondral bone, cause irregularity of articular surfaces, or produce maladjustment of the joint.

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Lessons Learned from Operative Deaths Related to Anesthesia*

In anesthetic accidents, as in automobile accidents, the difficulties were due more to human errors than to failures in equipment or drugs. Careless handling of short-acting intravenous barbiturates was a notable factor. Inadequately treated preexisting cardiovascular disease was responsible for many of the deaths. About a fourth of the tragedies would have been prevented if a properly staffed and equipped recovery room had been used.

When considering deaths related to surgery and anesthesia a particular agent or combination of agents, or type of technic are frequently indicted as the cause of death. This is often done with nothing but a clinical impression to substantiate the accusation. Or, a sudden surgical death arouses us from our routine patterns to alert us to the ever-present element of danger in surgery and anesthesia. Unfortunately, we do not take the time to probe the circumstances that resulted in the death, and we fail to learn as much as we should from our experiences.

To refresh our memories, to evaluate our agents and technics, and to attempt to draw out some worthwhile conclusions, we have reviewed all deaths in the last five years that occurred on the day of, or on the day following surgery and the results of all cases of cardiac arrest that have occurred in the operating room. It was thought that deaths occurring on these two days would be more closely associated with anesthesia, rather than extending this study to include all deaths that have occurred following surgery. Maternal deaths and operations involving surgery of the heart primarily were excluded from the study.

Incidence

During the years, 1951 to 1955, inclusive, a total of 28,200 surgical operations were performed in St. Joseph Hospital in Paterson. In 36 cases, death occurred within 48 hours of operation. Cardiac arrest occurred in nine of these 36 cases or a total incidence of 1 to 3100. Two cases of arrest were successfully revived (22 per cent).

The physical status of all patients was established pre-operatively according to the classification of the American Society of Anesthesiologists.

*Presented before the Section on Anesthesiology, The Medical Society of New Jersey, May 15, 1956. This work is from the Anesthesiology Department of the St. Joseph Hospital in Paterson, N. J.

Class 1. No organic pathology or patients in whom the pathologic process is localized and does not cause any systemic disturbance or abnormality.

Class 2. A moderate but definite systemic disturbance, caused either by the condition that is to be treated by surgical intervention or which is caused by other existing pathological processes.

Class 3. Severe systemic disturbance from any cause or causes. It is not possible to state an absolute measure of severity. This is a matter of clinical judgment.

Class 4. Extreme systemic disorders which have already become an imminent threat to life regardless of the type of treatment. Because of their duration or nature there has already been irreversible damage to the organism.

Class 5. Emergencies that would otherwise be graded as Class 1 or Class 2.

Class 6. Emergencies that would otherwise be graded in Class 3 or 4.

ANESTHETIC AGENTS USED

IN 11 of the 36 cases, the anesthetic was *via* endotracheal intubation. In all, counting the number of administrations, the agents used were:

	Administrations
Cycloprane	23 or 33%
Ether	13 or 18%
Nitrous Oxide	8 or 11%
Succinyl Choline (Anectine®)	7 or 10%
Tetracaine (Pontocaine®)—Spinal	3 or 4%
Thiopental (Pentothal®)	10 or 14%
Tubocurarine (d-Tubocurarine)	7 or 10%
	71 or 100%

The percentage distribution closely approximates the distribution of these agents in daily operating-room use. Thus, 33 per cent of the deaths were in patients receiving cycloprane; and 33 per cent of the successful (non-fatal) administrations were also in patients receiving cycloprane.

CATEGORIES OF DEATHS

DEATHS were categorized into these four groups: death due to (1) anesthesia mismanagement; (2) hemorrhage; (3) existing disease and anesthesia mismanagement; and (4) existing disease without anesthesia mismanagement.

ANESTHETIC MISMANAGEMENT DEATHS

FOUR deaths were due to anesthetic mismanagement. A survey reveals that death was due primarily to anoxia from respiratory obstruction or respiratory depression. Simple factors of constant and close attention to maintaining an adequate airway and to the total dose of the anesthetic agent would have prevented these fatalities.

This points out the danger in abusing a valuable drug such as thiopental (Pentothal Sodium®). Regurgitation of stomach contents can occur with the use of thiopental (Pentothal®) even in the patient with a so-called "empty stomach." It should warn us that supplementation of any anesthetic technic with thiopental (Pentothal®) implies the danger of silent regurgitation and tracheal aspiration of foreign material. Also highlighted is the potential danger of using intravenous drip solution without constant check of the total quantity of drug accumulating in the patient. As far as thiopental is concerned, it is our belief that no more than a Gram of the drug should be used in any solution. It should be administered so that it cannot run inadvertently into a vein too quickly. For the usual case, no more than a total of one Gram per operation should be used. If more than that is required, some other means of supplementation should be sought.

The only pediatric death occurred in a child who was partly obstructed over a long period even though intubated. It reminds us that hypoxia can occur even though we are using technics to prevent it from happening. It can be avoided only by constant attention to its early signs and correcting the fault immediately, going so far as to stop the surgery and undraping the patient to readjust and to secure firmly the equipment being used.

The final lesson drawn from the survey of this group is that there is no substitute for close observation of the patient in the post-anesthetic period with immediate available means *at hand* for correcting acute complications. The efficiently-run recovery room provides this.

These preventable anesthetic deaths were

not due primarily to any particular agent or technic. They were caused by the human deficiency of carelessness, lack of attention to basic facts and failure to apply corrective measures early enough.

DEATHS DUE TO HEMORRHAGE

FOUR deaths were due to hemorrhage. Three out of the four might be classified as preventable. Although they were not related to anesthetic management, the observations and advice of the anesthesiologist might have salvaged some of these cases.

These patients were returned to their hospital rooms following surgery. Being under the supervision of floor personnel, early signs of bleeding were interpreted as postoperative shock, rather than hemorrhage. Consequently, in two cases no definitive steps were taken to control the bleeding. In another case, steps taken were too late to effect survival. If these patients had been in a recovery room, under care of specially trained personnel and under constant observation by an anesthesiologist, early re-operation might have been advised for control of the bleeding. The diagnosis of hemorrhage rather than shock would then have probably been made.

In persistent hemorrhage, if active steps to control bleeding and multiple transfusions are unsuccessful, consider the possibility of incompatibility and derangement of the clotting mechanism. Under these circumstances, a new filter set should be used with each added unit of blood. Calcium gluconate should be given intravenously for every three pints of blood added. The patient's blood should be re-cross-matched with the new blood after several pints have been given. The more blood given, the fresher it should be.

EXISTING DISEASE AND ANESTHETIC MISMANAGEMENT

ELEVEN deaths were due to a combination of existing disease and anesthetic mismanagement. Many patients come to elective surgery with diseases other than the one to be corrected by operation. These "other" diseases caused death, aided by some deficiency in anesthetic management. Once the patient is in the operating room, the surgeon relies on the anesthesiologist for the medical as well as the anesthetic care of the case. Most of these patients died because pre-existing cardiovascular disease had reduced their ability to withstand the operative and anesthetic procedures they had to undergo. Anyone anesthetizing the patient with heart disease should know that such a patient cannot tolerate any severe degree of insult. Five of these patients showed signs of beginning heart failure during surgery without adequate efforts at correction. There is need for a quick-acting digitalizing agent for use during surgery and anesthesia. The drug must act effectively within minutes rather than hours to be of use. The anesthesiologist must be able to detect a failing heart under anesthesia and aid it if possible. The patient with hypertensive heart disease seems particularly vulnerable, according to this survey.

Three patients might have survived if a regional or topical anesthesia was used instead of a general anesthetic technic. Noteworthy, is the selection of anesthesia for bronchoscopy or esophagoscopy. These procedures are much more safely done under local anesthesia, particularly in patients with heart disease, until a general technic is perfected which gives the anesthesiologist complete control of ventilation and oxygenation of the patient.

From the strictly medical point of view, postanesthetic care was deficient in five cases because lack of a recovery room prevented the attention, treatment and advice an anesthesiologist should contribute. If it had been available, it is believed several survivals would have resulted.

Multiplicity of agents has been frequently condemned in discussions of present day trends of anesthesia. Except for their use during endoscopy, we cannot indict them as outstanding factors contributing towards these deaths. Rather, the stormy inductions and delayed and difficult intubations, under older technics, such as cyclopropane-ether anesthesia seem to have produced more bouts of hy-

poxia during the management of the anesthetic period.

Emergency tracheotomy in the operating room or in the postoperative period reveals the need for some immediate procedure to supply a temporary airway until the tracheotomy can be accomplished. It is suggested that a large bore cannula, such as a 14 gauge needle, be kept in each anesthesia machine. If the occasion arose, this could be inserted between the tracheal rings and oxygen or air insufflated into the trachea while the tracheotomy is being done. Its effectiveness remains to be seen.

Five cases reveal faulty pre-operative workups or evaluation. The anesthesiologist must share the blame for this. It is his responsibility to study each case before surgery. Deficiencies noted should be called to the surgeon's attention. Effort should be made to have them corrected. Knowledge of these deficiencies before anesthesia is essential for proper conduct of the anesthetic period.

DEATHS DUE TO EXISTING DISEASE

Fourteen deaths were due to existing disease without anesthetic mismanagement. The existing disease was too severe to be corrected by surgery in most of the cases. These cases presented the problem to the surgeon of making the decision to operate after weighing the risk of the patient against possible surgical relief. It is a situation occurring frequently and to which there are no clear cut answers. Most of these are emergency cases. The patients were of poor physical status and mostly in late middle life or elderly. There were more deaths in this one group than in any of the three groups listed above. This reflects the hazard of emergency surgery where the patient is acutely ill, often critically ill; where the patient is poorly or hurriedly studied preoperatively by the surgeon and most often not seen at all by the anesthesiologist; and where the patient is usually in the older age groups. Perhaps more time should be devoted to preoperative study and corrective care of the patient before emergency surgery.

CARDIAC ARREST

Nine patients suffered cardiac arrest; seven died. Two were resuscitated. In general, cardiac arrest in the operating room presents a very discouraging picture. Although heart action was re-established in all but one case, all patients but two died of cerebral anoxic changes. Of the two who survived, one exhibited persistent mild cerebral symptoms. Our results have been poorer than those reported elsewhere. The fact that these hearts were revived but cerebral damage resulted indicates that delay in opening the chest and delay in diagnosis were the factors principally responsible for these fatalities. Until the anesthesiologist and surgeon are properly conditioned to rapid, heroic action, these poor results will persist. It is the duty of the anesthesiologist to carry on a continuous program of education for all operating room personnel in proper resuscitative measures as long as the danger of "cardiac arrest" persists in surgery.

The term "cardiac arrest" is often used as the specific cause of death incorrectly. The processes producing the cardiac arrest are the true causes and the ones we wish to prevent. Hemorrhage, trauma, anoxia from respiratory obstruction or poor ventilation, or anoxia of circulatory origin are the real causes of death.

Cardiac arrest can occur while using any agent or any technic. Most occurred while thiopental was being used. Six out of the nine cases involved this drug. The ease with which it is administered carries with it the danger of carelessness in its management. Its ability to "knock out" physiologic protecting mechanisms should always be borne in mind before it is selected for a particular case.

Many of these patients had existing cardiovascular disease. This made them prone to the strain of anoxia or reflex activity. The fact that their heart action could be re-established, even though they were diseased, should stimulate us to quicker and more vigorous attempts at resuscitation to prevent cerebral changes and death.

Considering the two cases which survived, the arrest occurred in one during induction and the other during extubation when the arrest

was more easily recognized and immediate steps were taken to resuscitate the heart. This illustrates the fact that there is no substitute for close attention and rapid corrective action if fatalities are to be prevented.

The disturbing thought remains that delay in opening a chest will continue in the future. An artificial pace-maker applied to the chest during the period from the diagnosis of cardiac arrest until the chest is opened and the heart actually observed may be the salvation of these patients. Further clinical work with this apparatus is necessary to prove its effectiveness or to see if danger may result from relying on it as a substitution to thoracotomy and massage.

COMMENT

ANALYSIS of surgical patients who died more or less unexpectedly, revealed the meager resources from which we can draw true conclusions in determining causes of death. Hospital charts, surgeons' operative records and progress notes yielded very little information devoted to the events leading up to death and were practically devoid of any surgical opinions analyzing the death. Anesthetic records were just as much at fault. The lack of postmortem examinations is appalling especially when an autopsy could be so valuable in determining more exactly why a patient died. Our present means of determining causes of death are so inaccurate that every effort should be made to establish cause if we are to reduce needless mortality.

CONCLUSIONS

1. Aside from overwhelming disease, anoxia from respiratory obstruction or respiratory and circulatory depression was the prime cause of death during or immediately following surgery.

2. Human errors in management were responsible for most fatalities.

3. Multiple agents are to be condemned only when the person administering them is deficient in their management.

4. Short-acting intravenous barbiturates, carelessly handled, were the most treacherous of the agents used.

5. A large proportion of the patients who died had cardiovascular disease unsatisfactorily treated. The need for better therapy is apparent.

6. A recovery room would have probably saved 9 out of the 36 cases reported. A recovery room should be as much a part of every operating suite as the scrub room.

7. Emergency cases presented fertile ground for surgical and anesthetic mortality. Extreme precautions should be taken in their management.

8. Present methods of cardiac resuscitation were valueless unless all personnel knew what to do and did it promptly.

9. Diseased hearts undergoing "cardiac arrest" during surgery can be revived and an immediate attempt always should be made to do so.

703 Main Street (Dr. Lawless)

A display of six detailed tables appears in the authors' reprints.

Frederick C. Licks, M.D.

South Orange

Dermatologic Aspects of Mycotic Infections*

Here is a rapid review of an often-neglected branch of dermatology. Dr. Licks focuses especially on mycologic problems in New Jersey.

The dermatologist, both by training and experience, is familiar with medical mycology. He uses this knowledge in daily practice, especially in the handling of superficial fungus diseases. Diagnostic laboratory procedures are part of his everyday office routine. He knows the common contaminants in order to rule them out as possible pathogens. Allergic phenomena such as *id* reactions must be considered, as well as immunologic tests with fungus extracts. Finally, his clinical knowledge of the mycoses is a great advantage in knowing what to look for and what to expect from the laboratory. To physicians in other fields, the dermatologist can be of valuable assistance in the diagnosis and treatment of the systemic as well as the superficial mycoses.

Medical mycology is older than bacteriology, having its beginnings in Western Europe over a century ago. However, it has lagged far behind bacteriology, especially in classification and general knowledge. Interest in mycology quickened with the work of Raymond Sabouraud and other workers. Today the literature abounds with various articles on medical mycology, as witness the recent interest in moniliasis and histoplasmosis.

Classification is still a major problem. For the dermatologist, the most practical working classification is that which correlates the causative parasites with the diseases they cause. Conant[1] states that Candida albicans has 172 synonyms. This type of confusion is being eliminated as our knowledge increases.

Generally, the mycoses are divided into two broad groups: the superficial, and the deep (or systemic) fungus diseases. In the superficial type, the fungi live in the keratin of the skin, including the hair and nails, and (with the exception of Candida albicans) never invade the deeper organs. Some forms are so mild as to exist without the patient being aware of it. The systemic mycoses, on the other hand, not only invade the deeper skin, but tend to metastasize to internal organs, often fatally.

Fungus diseases are named by their geographic location, as North American blastomycosis; by clinical description, as pityriasis versicolor; or by the causative organism, as actinomycosis or trichophytosis. All methods leave much to be desired. A fungus may cause varied lesions in different locations while several fungi may cause nearly identical lesions in the same location. The type of lesions developed depends more on the locality and type of skin than upon the specific parasite. Most authorities and writers now classify the superficial mycoses according to the region involved such as tinea capitis, tinea cruris, and so on.

Most fungus infections are world wide in distribution. While not as important as bacteria and viruses as a cause of disease in man, they rank high in the number of cases pro-

*Read before the Section on Clinical Pathology, Annual Meeting of The Medical Society of New Jersey, May 15, 1956.

1. Conant, James: *Manual of Clinical Mycology*. 1954. Philadelphia, Saunders.

duced and the disabilities they cause. They form a large proportion of the cases seen by the dermatologist. In fact, almost everyone is affected at some time or other as the skin is particularly susceptible to invasion by these parasites.

Allergic phenomena such as *id* reactions are seen. They are named trichophytid, moniliid, and so on according to the causative agent. While any type of lesion may be produced, the usual one is a vesicular eruption on the palms and sides of the fingers secondary to a severe or overtreated fungus infection of the feet. No fungi can be recovered from the *id*. The condition is caused by blood-borne fungi or their products setting up an allergic reaction. Treatment of the original site usually clears up the *id*.

While the dermatologist can diagnose many of the common fungus infections clinically, laboratory tests are occasionally necessary. Fungus infections of the eczematoid type may closely resemble non-mycotic infections. Some skin conditions may be nearly identical with other fungus diseases. Even when the diagnosis is clear, the identity of the causative organism may be necessary for the proper treatment and prognosis. Anyone treating fungus diseases should know these procedures. Most of them are simple to do.

LABORATORY PROCEDURES

THE two most useful laboratory procedures for routine work are the direct microscopic examination and cultures. Both are usually necessary. The microscope gives valuable information when the fungi will not grow on culture. The culture allows one to identify the species of the fungus.

The proper selection of material is important. In fungus infections of the nails, sometimes the debris under the nail will be loaded with fungus elements while scrapings from the surface may be negative. In tinea capitis, the short broken hairs are usually infected while the longer hairs may not show anything. Wood's or filtered ultra-violet light will usually produce characteristic fluorescence of the infected hairs, making them easy to pick out.

Suspected material is placed in a 10 to 40 per cent solution of potassium hydroxide under a cover slip. It may be allowed to stand from a few minutes to many hours depending on the thickness of the material. Gentle heating may help. The preparation may be kept overnight in a moistened petri dish without drying. Staining technics have been improved greatly in recent years but most specimens do not require staining. Only a standard culture medium should be used. Fungi will grow differently according to the media. Two of the best are Sabouraud's dextrose agar and Littman oxgall agar.[2] I make my own media from standard formulas using large (one inch by eight inch) test tubes. It is practical, however, for a physician to purchase prepared media, which usually come in smaller test tubes or in small, square "perfume" bottles.

The cultures of the superficial fungi are incubated at room temperature. The deep fungi are grown in the same manner, but in addition, other cultures on various media should be made and incubated at 37 degrees centigrade. The deep fungi will grow as a filamentous fungi at room temperature and as a yeast at body temperature. Both methods should be used for identification.

For further identification, culture mounts for microscopic examination are made of the mature colonies. Lactophenol® with cotton blue is ideal for this purpose as it kills, fixes, clears and stains all in one operation. A common error is to throw out the cultures too soon. Unlike bacteria, fungi grow slowly. Cultures should be observed three or four weeks before discarding.

Another common error is to see too much in the microscopic examination. The microsporons in the hair all look alike as do the trichophytons, although the latter can be divided into the ectothrix and endothrix varieties. Cultures are needed to determine the species. The skin scrapings of tinea cruris or tinea corporis, all look alike. Describing findings as "fungi of the ringworm type" is suffi-

2 Moss Morris and McQuown, Morris: *Atlas of Medical Mycology*. 1953. Baltimore, Williams and Wilkins.

cient. On the other hand, malassezia furfur, the cause of tinea versicolor, can be identified by the microscope alone.

DISTRIBUTION

TYPES of fungi vary in different parts of the country; even in the same locality they may vary from year to year. I confine the comments below to the incidence of fungi and fungus disease in New Jersey.

Years ago, microsporon lanosum (syncanis) was the most frequent cause of tinea capitis but at present microsporon audouini accounts for nearly all the cases. While both spread from human to human, microsporon lanosum is often acquired from some animal such as a dog or cat. They may be hard to differentiate clinically although microsporon lanosum is more inflammatory in reaction and often produces kerions. Because of this reaction, it is easier to cure. X-ray epilation is often used for microsporon audouini infections as it is a stubborn disease. They fluoresce alike under the Wood's light and they are similar on microscopic examination. Cultures are needed to differentiate the two.

TINEA

INFECTIONS due to microsporon fulvum, tricophyton violaceum, tricophyton sulfureum and tricophyton schoenleini (Achorian) are occasionally seen. The latter causes *favus* — a chronic, scarring scalp affection found in all age groups.

Most cases of tinea capitis are limited to children below the age of puberty at which time they usually clear spontaneously.

In 1954, through recommendations of the New Jersey Dermatological Society, The Medical Society of New Jersey went on record as favoring the admission of tinea capitis children to school, providing they were under treatment. Keeping children out of school, often for long periods, served no useful purpose, and interfered greatly with the normal life of the child.[3]

TRICOPHYTON

TRICHOPHYTON rubrum (purpureum) is most frequently found in ringworm infections of the nails, feet, groin, beard and glabrous skin. Tricophyton mentagrophytes (gypseum) was formerly found more frequently than now. Years ago the epidermophyton floccosum was a common offender. In fact, Sabouraud named it epidermophyton inguinale because of its frequent isolation from the groin. Tricophyton rubrum invokes little or no immunologic response and as a result is one of the most difficult infections to clear up.

Fungus infections of the ear are probably far less common than generally supposed. At one time almost every infection of the ear was called a mycosis. Serious workers have a difficult time confirming the diagnosis. Most are caused by bacteria. Since the causative agents are usually the large saprophytic fungi rather than the ringworm types, they should be easily detected on microscopic examination, in fact colonies are sometimes seen grossly. Cultures are misleading as a few spores of these fast growing saprophytes can produce large colonies in a short time.

CANDIDIASIS

CANDIDIASIS is now the accepted name for Moniliasis and Candida albicans for the organism, Monilia albicans. Candida albicans contains both filamentous and yeast forms and can produce lesions varying from the insignificant to the fatal, as in candidiasis of the lungs. Since the use of antibiotics and their side effects such as pruritis ani and diarrhea, this organism has received a great deal of attention in the literature. Candida is often found normally in the stool—so much so, that for years it was thought to be the cause of sprue. When such competing organisms as bacteria

3. Licks, Frederick C.: JOURNAL of The Medical Society of New Jersey, 51:515 (December 1954).

are killed off by the antibiotics, the candida or monilia may multiply unimpeded. Various agents to increase the intestinal flora and the addition of vitamins have been used of late. Nystatin* offers great promise.

Candida albicans can live on normal tissues without causing disease. It is particularly prone to attack the debilitated as in malnutrition, infants, the aged, diabetics, and the markedly obese. The disease is given different names according to location. In the mouth of infants it is called *thrush*; in the corners of the mouth, *perleche;* in the intertriginous folds, especially in the obese it is *intertrigo* and in the cuticle where it is termed *paronychia.* A common infection in the finger webs, especially of the third and fourth webs has small areas of involvement but receives the long name of *erosio interdigitalis blastomycetica.* It will also involve other specific locations as the mouth and vagina and occasionally invade the deeper organs.

Many erroneous diagnoses of candida of the vaginia as well as other parts are made. This is especially true if cultures alone are relied upon. On a suitable medium, a few spores will multiply into large colonies without actually being the cause of any disease. If there are enough organisms to cause symptoms, they should be plainly evident in large numbers in the freshly made microscopic preparation.

The deep mycoses are occasionally found in New Jersey, especially sporothricosis, actinomycosis, North American blastomycosis and cryptococcosis. I had three cases of sporothrichosis, one in an adult and two in children. While rare, probably more of these mycoses would be found if they were considered in the differential diagnosis of every obscure disease. Often the incidence of cases varies directly with the intensity of the search.

*Tradenamed by Squibb as Mycostatin®.

64 Scotland Road

Alcohol and Ulcers

Concentrated alcoholic drinks may lead to hemorrhages or ulcers, especially if the drinks are taken on an empty stomach.

This is the conclusion of Dr. A. Wynn Williams,* senior lecturer in pathology, University of Edinburgh, based upon the examination of the gastric mucosa of adults with a history of alcoholic excess, combined with a detailed study of the effects of alcohol on the guinea pig stomach. Drinks containing small concentrations of alcohol, such as beer, might be well tolerated even when taken in excess for many years. Experiments show that hemorrhages, erosions and ulcers are found in the stomach following the administration of alcoholic solutions in concentrations of 20 per cent or more. The greater the concentration of alcohol, the more severe the lesions. Increasing the volume of alcohol tended to increase the severity of the gastric lesions, as did fasting.

*Williams, A. W.: British Medical Journal 1:256 February (1956)

June 24 Trustees Meeting

At its meeting on June 24, 1956, the Board of Trustees took the following actions:

—Instructed the Special Committee on Medico-legal Testimony to work with the appropriate committee of the New Jersey Bar Association to formulate a code to govern relations between physicians and lawyers.

—Referred to the Trustees of Medical-Surgical Plan the House of Delegates resolution concerning future changes in the Medical-Surgical Plan contract.

—Received from the House of Delegates and referred to the Subcommittee on Medical Practice the following resolution:

Resolved, that The Medical Society of New Jersey be urged to attempt to have the law in New Jersey changed in order to provide for the direct payment of physicians for medical services rendered to recipients of Old Age Assistance as contrasted with the present procedure whereby the Welfare Board pays the recipient who in turn is expected to pay the physician.

—Adopted a meeting schedule for the 1956-7 year.

—Authorized the Chairman of the Board and President of the Medical Society to select Counsel for the Society.

—Appointed Dr. Blaugrund and Dr. Gardner as our representatives to the Princeton session of the New Jersey Health and Sanitary Association.

—Confirmed the action of President Fritts in nominating certain physicians for service to the Commission created by Assembly Joint Resolution No. 1.

—Named Dr. Carl N. Ware to the State Committee to study Mental Deficiency.

—Received and referred to the Mental Health Committee a report from Dr. Edward P. Duffy, Jr., on the Health Education Conference. Dr. Duffy reported that:

"'The Family as a Focal Point in Health Education' was the theme of the conference. It was slanted toward all disciplines concerned with health, education, and mental hygiene. Some previously active health organizations apparently wish to enter the field of mental health with all of their personnel. They have many 'family contacts,' and because tuberculosis and poliomyelitis workers are no longer needed in the same capacities as previously, because medical science has conquered to a considerable extent those dread diseases; rather than disband their organizations or change the routine of their services, mental health is being considered as an outlet for their energies. The trend has merit, because if nothing else, it points out the developing impact of mental health in all communities and in all health activities. Yet, it would seem to me that medical men must be cautious in permitting association of their names and support to an organization, *viz.* New Jersey Tuberculosis League, being a sponsor of a purely mental health program and spending monies collected for tuberculosis, in mental health work."

—Received a resolution from the New Jersey Ophthalmologic Society which recommended that we support a clinical glaucoma detection program for 1957 conducted by the profession under the auspices of The Medical Society of New Jersey or the New Jersey Ophthalmologic Society.

The President referred the matter to the Special Committee on Conservation of Vision, asking what would be entailed in such a program "under the auspices" of the Medical Society. The Special Committee reported that such a program, being a purely medical enterprise should be sponsored by the Medical Society and conducted by physicians (ophthalmologists). The committee added that the assistance of a lay organization in the promotion of such program would be acceptable. The Ophthalmologic Society offers its support and cooperation. Accordingly, the Special Committee on Conservation of Vision submitted the following resolution:

Resolved, that a clinical glaucoma program be authorized and conducted in New Jersey during 1956 under the auspices of The Medical Society of New Jersey.

Dr. Schaaf pointed out that the Glaucoma Detection Program has for several years been a project of the New Jersey State Commission for the Blind. While it is desirable that a program of this type be conducted by medical organizations, it is neither proper nor right for the Society to take over another organization's program. The Board concurred. The Trustees finally adopted a motion which approved,

in principle, the New Jersey Commission for the Blind's 1950 Clinical Galucoma Detection Program and recommended that the Special Committee on the Conservation of Vision cooperate in the furtherance of such project.

—Approved of the following "Guide to Committee Functions" developed by the President:

Cancer Control—to study and evaluate for the approval of The Medical Society of New Jersey programs in cancer control, and to make formal recommendations in this field relative to official policies and positions of The Medical Society of New Jersey.

Maternal and Infant Welfare—to study and evaluate for the approval of The Medical Society of New Jersey programs in maternal and infant welfare, and to make formal recommendations in this field relative to official policies and positions of The Medical Society of New Jersey.

Legislation—to study and evaluate legislation—at state and national levels—proper to the interests of The Medical Society of New Jersey. The recommendations of the subcommittee are subject to the approval of the Welfare Committee and of the Board of Trustees before they are adopted as the official position of The Medical Society of New Jersey. Other assignments in the field of legislative concern, such as the preparation of desirable legislation, may be given to the subcommittee at the discretion of the House of Delegates or the Board of Trustees.

Medical Practice—to exercise responsibility for the study and evaluation of matters relevant to the maintenance and advancement of the standards and character of medical practice in New Jersey; to pass upon the projects and recommendations of the special committees to the subcommittee, and to make formal recommendations in the field of medical practice relative to official policies and positions of The Medical Society of New Jersey.

Public Health—to study and evaluate all matters of interest to The Medical Society of New Jersey in the field of public health, to pass upon the projects and recommendations of the special committees to the subcommittee, and to make formal recommendations in the field of public health relative to official policies and positions of The Medical Society of New Jersey.

Public Relations—to assume responsibility for evaluating and suggesting programs and projects calculated to further the public relations of The Medical Society of New Jersey as regards the relation of doctor-and-doctor and doctor-and-patient, and the relations of medicine as an organized unit with the general public. The findings and recommendations of the Subcommittee on Public Relations are subject to the approval of the Welfare Committee and the Board of Trustees.

Industrial Health—to study and evaluate matters relevant to improvement and maintenance of standards of health in industry and of the practice of industrial medicine, and to make formal recommendations in this field relative to official policies and positions of The Medical Society of New Jersey.

Workmen's Compensation—to study and evaluate all matters affecting the interests of the profession and the general public in the field of workmen's compensation and disability benefits under the laws of New Jersey, and to make formal recommendations in this field relative to official policies and positions of The Medical Society of New Jersey.

Chronically Ill—to study and evaluate all matters concerned with the care of the chronically ill, and to make recommendations in this field relative to official policies and positions of The Medical Society of New Jersey.

Conservation of Hearing and Speech—to study and evaluate matters concerned with the conservation of hearing and speech, and to make formal recommendations in this field relative to official policies and positions of The Medical Society of New Jersey.

Conservation of Vision—to study and evaluate matters concerned with the conservation of vision, and to make formal recommendations in this field relative to official policies and positions of The Medical Society of New Jersey.

Mental Health—to study and evaluate all matters relevant to the maintenance of mental health, and to make formal recommendations in this field relative to official policies and positions of The Medical Society of New Jersey.

Rehabilitation—to study and evaluate means of effective rehabilitation for the diseased and incapacitated, and to make formal recommendations in this field relative to official policies and positions of The Medical Society of New Jersey.

Routine Health Examination—to develop a screening type of physical examination, to be done in the physician's office, which will be adequate to detect abnormalities and determine functional capacities where necessary, and to make recommendations concerning the adoption of such examinations as an official project of The Medical Society of New Jersey.

School Health—to study and evaluate all matters relevant to the establishment of a uniform health program for school children, and to make formal recommendations in this field relative to official policies and positions of The Medical Society of New Jersey.

Emergency Medical Service and Civil Defense—to study and evaluate methods and procedures for rendering emergency medical service, and for dealing with the medical aspects of civil defense, and to make formal recommendations in these fields relative to official policies and positions of The Medical Society of New Jersey.

Physicians Placement Service—to evolve and operate a satisfactory system of physicians placement in New Jersey through the instrumentality of the physicians placement service bureau, and to make formal recommendations in this field relative to official policies and positions of The Medical Society of New Jersey.

Widows and Orphans of Medical Men—to coop-

erate with the Society of Widows and Orphans of Medical Men of New Jersey to the end that the membership in that organization may be increased and its services rendered more effective, and to make formal recommendations in this field relative to official policies and positions of The Medical Society of New Jersey.

Revision of Constitution and By-Laws—to study and evaluate for substantial and formal accuracy all proposed amendments to the Constitution and By-Laws, and in general to exercise responsibility for the preservation of the adequacy and accuracy of the provisions of the Constitution and By-Laws, and in that connection to make official recommendations to the House of Delegates.

Medical Student Loan Fund—to administer the program approved by the 1956 House of Delegates authorizing the establishment of the committee and the fund, and to make formal recommendations in this field relative to official policies and positions of The Medical Society of New Jersey.

—Referred to the Committee on Public Health a proposal for a demonstration tuberculin test pilot project in Mercer and Somerset Counties.

—Received the report of the A.M.A. delegates.

—Authorized the delivery to Dr. David B. Allman of the following letter:

Dear Dave:

Your colleagues of the Board of Trustees and, indeed, all your fellow members of The Medical Society of New Jersey, rejoice in the fact that you have been unanimously chosen President-Elect of the American Medical Association.

We appreciate that as a Society we share in the honor conferred upon you, but we know that the fundamental reason for your election to this high and responsible office is your splendid capacity for service and for leadership. You have long been marked for greatness.

We are proud of you and of your accomplishments. May the years ahead be years of unparalleled attainment for the good of Medicine and your fellow citizens. You have won recognition and commendation for what you have already done for our fellowmen. It is our hope that your accomplishments as the leader of American Medicine will be unique for greatness and true worth.

Our hearts are already yours. Our services are yours to command.

Sincerely yours,
CARL N. WARE, M.D., *Secretary*
Board of Trustees

—Approved the report of the Advisory Committee to the Woman's Auxiliary.

—Approved the recommendations of the Subcommittee on Legislation with respect to the following bills:

S-112 *Ridolfi*—Eliminates prohibition against the issuance of a marriage license when either of the contracting parties is an epileptic. *Approved*

This measure is approved because the Society agreed to official sponsorship of the measure.

A-384 *MacDonald*—Excludes ophthalmic technicians from application of provisions regulating ophthalmic dispensers and technicians. *Disapproved*

The subcommittee agreed, in conformity with its action concerning a similar bill in the previous session, to recommend that this measure be disapproved, with the understanding that should the bill move, we will adopt a position of active opposition.

A-414 *Maebert*—Requires physicians, dentists, and pharmacists prescribing or compounding a prescription to be administered to a child under age four, to include in such prescription the name and dosage and directions for use; prescribes penalties from $100 to $200 for the first offense and of at least $200 for subsequent offenses; effective thirty days after enactment. *Approved in Principle*

The opinion prevailed that this bill has a laudable intent but is an unsatisfactory means for the end sought.

A-436 *Maebert*—Exempts holders of medical licenses from the provisions of the act requiring licensing of bio-analytical laboratories and technicians. *Approved*

A-480 *Sherman*—Provides that no chiropractic school shall be disapproved because it is not nonprofit, if it meets other conditions. *Disapproved*

If bill moves, position becomes one of Active Opposition.

A-504 *Smith*—Extends the application of specified qualifications for a license to practice medicine and surgery until December 31, 1959, instead of until December 31, 1957.

Since the bill was not reported in the current *Legislative Index*, the subcommittee voted to take no action at this time.

A-505 *Smith*—Permits persons who have declared their intention to become citizens of the United States to be temporarily licensed to practice medicine and surgery pending naturalization up to December 31, 1957. *Active Opposition*

This bill is actively opposed in conformity with the established position of the Society actively to oppose any and all measures that weaken the Medical Practice Act.

Annual Registration—The proposed legislation for annual registration was discussed fully. Two forms of the legislation were considered, and the subcommittee favored the form which would impose a money penalty rather than a suspension of license, and agreed to so recommend to the Board of Trustees.

The Chairman told the members present that he had been informed that in the Assembly there is opposition to the proposed legislation. Opposition of legislators centers about the fact that they consider that the measure imposes a limitation on the plenary character of the license presently granted to physicians and surgeons in New Jersey.

—Reaffirmed its previous action declaring ineligible for membership an osteopath who

had obtained, after one year at foreign medical school, an M.D. degree. The Board's resolution stated that:

" . . . the doctor in question is ineligible for membership in a county medical society, the State Society, and the A.M.A.—on the basis that he is licensed to practice as a Doctor of Osteopathy, that his M.D. degree is not recognized inasmuch as it was obtained without meeting the necessary four years' attendance at a recognized school of medicine, and that he is ineligible for examination to receive a license as an M.D."

It further directed that the attention of the Ethics Committee of the County Medical Society be called to that provision of the Charter of The Medical Society of New Jersey which states that, to qualify for membership, a person must have an M.D. degree acceptable to The Medical Society of New Jersey.

—Named Dr. C. B. Blaisdell and Dr. L. A. Mulligan as representatives to the Governor's Conference of Hospitals and Medical Services.

—Referred to the Subcommittee on Public Health the first resolution and to the Subcommittee on Legislation the second of the following resolutions from the Ocean County Medical Society:

(a) That The Medical Society of New Jersey take appropriate steps to apprise the New Jersey State Board of Health of the present inadequacies in the laws regarding quarantine and isolation, and work out with the State Board of Health a more realistic and modern approach to the problems of quarantine and isolation.

(b) That The Medical Society of New Jersey interest itself more actively in the drafting of legislation which would provide for a medical examiner system that would serve the entire State of New Jersey, including counties, such as Ocean, where the present coroner system is entirely inadequate and unsatisfactory.

Mailing Specimens to State Laboratory

Blood specimens mailed to the laboratory of the State Department of Health for serologic tests are subjected to the hazards of high temperature and contamination. To avoid the embarrassment and delay incident to collecting repeated blood specimens from patients, physicians are asked to: (1) Mail specimens as early in the week as possible, so that there will be no weekend or holiday "lay-overs"; (2) keep specimens in refrigerator until they are mailed and (3) take specimens with sterile dry needle and syringe to avoid contamination and hemolysis. These directions are always applicable, especially during the summer.

Obituaries • • •

Dr. LOREN H. CRABTREE

In 1895 Loren H. Crabtree was born in a log cabin in Indiana. He became an old fashioned school-master and musician on river boats. Then, at the age of 33, he decided to become a physician, and four years later, he was graduated from the medical school of Temple University. Long interested in gynecology and obstetrics, Dr. Crabtree was Associate Attending Obstetrician at the Elizabeth General Hospital at the time of his death. He had been conductor of the orchestra of the First Presbyterian Church, a choir singer in the Grace Episcopal Church, and active in the affairs of the Academy of Medicine of New Jersey. Dr. Crabtree died on the first day of summer, 1956.

DR. WILLIAM M. DOODY

Long active in psychiatric circles in the east, William Doody died on May 21, 1956. Dr. Doody was born in 1894 and received his M.D. from Fordham in 1919. He was interested in emotional problems in children from the start of his professional career. He founded the unique "travelling child guidance clinic" of New York's Catholic Charities. He was active in the American Group Therapy Association and was treasurer of that organization at the time of his death. Dr. Doody was a frequent contributor to the scientific forums of the American Orthopsychiatric Association. Some years ago, Dr. Doody was named director of the network of mental hygiene clinics operated by the Hudson County Mental Hospital.

DR. HENRY LEASE

At the untimely age of 56, Dr. Henry Lease, a well known general practitioner in North Bergen, died on June 29, 1956. A native of New York City, Dr. Lease was graduated in 1926 from the College of Physicians and Surgeons of Columbia University. In 1927 he completed his internship at St. Mary's Hospital in Hoboken and remained in our Hudson County ever since. For some years, Dr. Lease was a police surgeon for the city of North Bergen. He was active in the Hudson County Medical Society.

DR. CHARLES B. LUFBURROW

One of New Jersey's beloved senior physicians died on June 27, 1956 when Dr. Charles B. Lufburrow died in Plainfield at the age of 83. Dr. Lufburrow was graduated from the medical school of the University of Maryland in 1897. In 1900 he came to Plainfield. At one time he was city physician there. In 1909 he was appointed assistant surgeon at the Muhlenberg Hospital and by 1916 had become chief of surgery. He remained as surgical chief until 1934, when at the statutory retirement age of 63, he became consulting, later emeritus surgeon. Dr. Lufburrow was active in developing Plainfield's Selective Service Board in World War I—until the middle of 1918 when he was commissioned in the Army himself. In 1955, full of honors, Dr. Lufburrow retired.

DR. ROCCO S. MARRA

Dr. Rocco S. Marra, born in 1898, died on the fourth of July, 1956. In 1925 he was graduated from the medical school of George Washington University. In the following year he interned at St. Michael's Hospital in Newark. While in general practice, he became increasingly interested in both surgery and anesthesiology. He was an associate surgeon at St. Mary's Hospital in Orange and at the Columbus Hospital in Newark. He was also active in military-medical circles.

DR. CORNELIUS PERRINE

Himself a well-known Monmouth County cardiologist, Dr. Cornelius Perrine died of a heart attack on June 22, 1956. Dr. Perrine was only 50 years old at the time of his death. A graduate of the Jefferson Medical College in 1932, Dr. Perrine then came to Monmouth County to intern and practice. He had active military duty in both the Atlantic and Pacific as a navy medical officer between 1943 and 1946. A diplomate in internal medicine, Dr. Perrine was director of internal medicine at Riverview Hospital in Red Bank and attending physician at Monmouth Memorial. Dr. Perrine was, for some years, chief of the cardiology clinic at Monmouth Memorial.

DR. RICHARD J. SIMMONS

At the age of 42, Dr. Richard J. Simmons of Elizabeth died on July 17, 1956. After receiving his M.D. degree from St. Louis University School of Medicine in 1939, New York-born Dr. Simmons came to Elizabeth to intern. Here he remained to do general practice. Dr. Simmons was an active member of the Union County Medical Society.

DR. JAMES A. WHEELER

Dr. James Alexander Wheeler, one of Hudson County's senior otologists, died on June 29. Born in upper New York State in 1880, he was graduated in 1904 from the College of Physicians and Surgeons (Columbia University). For nine years thereafter he was a ship's surgeon, serving on the trans-Atlantic ocean greyhounds of the Holland-America line. In 1915 he land-based himself in Jersey City where he became increasingly interested in laryngology and otology. He was active in Masonic and Shrine affairs. Dr. Wheeler was attending otolayrngologist at the Fairmount Hospital in Jersey City.

Announcements • • •

New Jersey Cancer Symposium

Experts in the fields of cancer diagnosis and treatment will be the speakers on the programs of the seminar of the American Cancer Society, New Jersey Division, on Saturday and Sunday, November 17 and 18, at Hotel President, Atlantic City.

Speakers at the opening session on Saturday afternoon will include Dr. Jerome A. Urban, New York City; Dr. Eugene P. Pendergrass, Philadelphia; Dr. William W. Scott, Baltimore and Dr. Albert Segaloff, New Orleans. Breast and prostatic cancer will be among the subjects discussed.

There will be morning and afternoon sessions Sunday. Included among the speakers will be Dr. Herbert Brendler, New York City; Dr. Harry S. N. Greene, New Haven; Dr. C. Bernard Brack, Baltimore; Dr. Warren R. Lang, Philadelphia; Dr. A. C. Upton, Oak Ridge, Tenn.; Dr. Sidney Farber, Boston and Dr. Wayne Rundles, Durham, N. C. Topics include factors influencing the curability of cancer, leukemia, lymphomas, and cancer of the cervix and the gastro-intestinal tract.

Dr. Joseph 1. Echikson, of Newark, is chairman of the Professional Information Committee of the American Cancer Society, New Jersey Division, which will conduct the seminar. Further information may be obtained from the New Jersey Cancer Division, 9 Clinton Street, Newark.

Cancer Cytology Congress

A Cancer Cytology Congress, sponsored by the College of American Pathologists, the American Society of Clinical Pathologists and the Inter-Society Cytology Council, will be held at the Drake Hotel, Chicago, on October 9, 10, and 11, 1956. The program includes broad discussions on the practical values of cytologic technics. It should be of great interest to practicing physicians of all specialties in which cytology plays a part.

Copies of the program are available on request from Dr. Arthur H. Dearing, Prudential Plaza, Suite 2115, Chicago 1, Illinois.

Anesthesiology Course for General Practitioners

Wednesday mornings, starting on October 17 and terminating on December 19, a course in anesthesiology for general practitioners will be given at various places in northern New Jersey. Practitioners must register for the individual sessions or for the whole program, but no fee is charged.

Each session starts at 9 a.m. On October 17, the subject will be inhalation anesthesia; on October 24, rectal and endotracheal anesthesia; on October 31, spinal anesthesia and a general discussion of pre-anesthetic medication; on November 7, the topic will be intravenous anesthesia. On November 14, discussion will center on muscle relaxants; on November 21, on hazards and complications; on November 28, on obstetrical anesthesia; and on December 5, on cardiac arrest. December 12 will be devoted to pediatric anesthesia, and December 19, to regional anesthesia.

For details, registration and faculty listing, write to Dr. I. R. Hayman at 681 Broadway, Paterson. The first two sessions will be at the Jersey City Medical Center. The October 31 and November 7 meetings will be at the Newark Beth Israel Hospital. The Hackensack Hospital will be host for the November 14 and 21 sessions. On November 28 and December 5, the sessions will be at the Presbyterian Hospital in Newark. The last two meetings will be at St. Joseph Hospital in Paterson.

Cerebral Palsy Institute

On Saturday, October 20, an Institute on Cerebral Palsy will be held at the Berkshire Hotel in Reading, Pennsylvania. The program runs from 3 p.m. to 9 p.m. Dr. Temple Fay will be the principal speaker. Cases will be presented. The Institute is sponsored by the American Business Club (Reading, Pa., Chapter) and the Berks County (Penna.) Medical Society. There is no registration fee. Obtain details from Dr. H. L. Rudolph at 400 North 5th Street, Reading, Penna.

Psychosomatics in General Practice

The Academy of Psychosomatic Medicine will hold a meeting at the Hotel Plaza, New York City on Thursday, Friday, and Saturday, October 4, 5, and 6, 1956. This will be key-noted around psychosomatic aspects of the general practice of medicine.

Each morning will be given over to invited speakers. Among others, Dr. Milton Rosenbaum of the Albert Einstein College of Medicine will discuss the doctor's relationship to the patient. Dr. George Train of the State University will talk on pitfalls in the evaluation of psychotherapeutic results. Dr. Avery D. Weisman of Harvard will explore the psychiatric management of duodenal ulcer.

Dr. Robert B. Malmo of McGill University will discuss "A Neuropsychologic Theory of Anxiety."

Each afternoon there will be a panel discussion concerned with the psychosomatic aspects of obesity, on Thursday; "Where the Psyche Meets the Soma," on Friday; and on Saturday: allergic disease.

The meeting is open to all interested physicians. There is no registration fee. For details concerning the program and the speakers, questions should be directed to Dr. Ethan Brown at 75 Bay State Road, Boston 15, Mass.

English for Foreign-Born Physicians

Starting on September 27, and every Thursday evening thereafter, through January 17, a course in practical English for physicians will be held in New York from 6:15 to 8 p.m. For details, write to Division of General Education, 1 Washington Square North, New York 3, N. Y.

Urology Award

Prizes of $500, $300 and $200 await the winners of the American Urologic Association's 1956 contest. The award is for essays on clinical or laboratory studies in urology. Competition is limited to physicians who were graduated from medical school in 1946 or later. Deadline is December 1, 1956. Obtain further details from American Urologic Association, 1120 North Charles Street, Baltimore 1, Md.

Psychiatric Research Convention

October 27 at the Waldorf-Astoria in New York City, the Eastern Psychiatric Research Association will hold a one-day meeting at which will be presented papers on various aspects of applied psychiatry. A $100 award will be made to the author of the best paper.

On the previous day, Friday, October 26, there will be an intensive practical course on "Cerebral Electrotherapy" which will include a discussion of anesthesia. Fee for this is $25 and this includes actual participation.

For more details write to Dr. Theodore R. Robie, 676 Park Avenue, East Orange, N. J.

The Waking Brain

Salmon Lectures will be delivered Thursday afternoon and evening, November 15, 1956 by Horace W. Magoun, Ph.D., Professor of Anatomy at the University of California. His subject: "The Waking Brain." The lectures will cover the role of the reticular system in wakefulness and behavior. The lectures will be given at 4:30 and 8:30 p.m. at the New York Academy of Medicine in New York City, 103 Street at Fifth Avenue.

Writing Prize for Interns and Residents

The Delaware Valley Chapter of the American Medical Writers' Association announces the Silberman Foundation Award of $100 to the author of the best-written, previously unpublished, case report submitted prior to November 15, 1956. Manuscripts are submitted in duplicate to Miss Dorothy Harrison (Editor of *Philadelphia Medicine*), 301 South 21 Street, Philadelphia 3, Pa.

Manuscripts should not exceed 750 words. Interns and residents at all hospitals in New Jersey are eligible. Manuscripts by joint authorship are acceptable. Manuscripts will be returned if postage is forwarded.

Essay on Infertility

The Trustees of America's oldest medical essay competition, the Caleb Fiske Prize of the Rhode Island Medical Society, announce as the subject for this year's dissertation "Present Day Treatment of Infertility." The dissertation must be typewritten, double spaced, and should not exceed 10,000 words. A cash prize of $350 is offered. Essays must be submitted by January 10, 1957.

For complete information write to the Caleb Fiske Fund, Rhode Island Medical Society, 106 Francis Street, Providence 3, Rhode Island.

Diet Manual Available

The Pennsylvania Medical Society is now making available a new revised edition of its Manual of Therapeutic Diets. The first edition, issued several years ago, proved so popular that supplies were soon exhausted.

Over 30 separate diets are presented. These cover many nutrition needs from liquid diets through soft diets to various types of modified diets. Recommended daily dietary allowances are given as well as a food composition table for a short method of dietary analysis. The Manual is available at $1 per copy. Please send your check—or a dollar bill—to The Commission on Nutrition, 230 State Street, Harrisburg, Pennsylvania.

Diagnostic Service for Amputee Children

A free diagnostic service for amputee children, if referred by their physicians is available on Saturday morning, October 13, at the Kessler Institute on Pleasant Valley Way, West Orange. For further details write to the Institute, or telephone Redwood 1-3600 and ask for Dr. Hoerner.

Pennsylvania Society to Meet in New Jersey

New Jersey physicians are offered a chance to go to another state medical society meeting this fall. The Medical Society of the State of Pennsylvania meets in Atlantic City. The scientific program begins Tuesday afternoon, October 23 and runs through October 26. Headquarters are at Haddon Hall, and all New Jersey doctors are assured of a cordial welcome.

Cardiovascular Disease Course

Starting on October 8, a 5-day course entitled "Recent Advances in Cardiovascular Diseases" will be offered full time at New York Mount Sinai Hospital. Registration fee is $30 for members of the American College of Physicians and $60 for other doctors. Registration and full details from the American College of Physicians, 4200 Pine Street, Philadelphia 4, Pa.

Laboratory Diagnosis of Tuberculosis

The Public Health Service announces an intensive course in laboratory diagnosis of tuberculosis from January 21 to February 1, 1957. No tuition fee is charged, but advance reservation is required. The course is held in Chamblee, Georgia, and further information and application forms may be obtained from the Laboratory Training Services, Communicable Disease Center, Public Health Service, P. O. Box 185, Chamblee, Georgia.

TUBERCULOSIS *Abstracts*

Supplied by New Jersey Trudeau Society

ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXIX September, 1956 No. 9

Tuberculosis in Infants and Children

By John S. Chapman, American Review of Tuberculosis, March, 1956.

A review of tuberculosis in the younger age groups calls attention to certain persistent concepts which seem to be either erroneous or ill-founded. It seems advisable here to make preliminary mention of the therapy of certain localized forms of tuberculosis for which the methods of treatment may have to be revised.

The cases studied consist of 101 patients discharged from a pediatric hospital between 1949 and 1955, of whom 56 per cent were less than three years of age when admitted. This group represents a fairly accurate cross-section of the tuberculosis problem in this area.

Admission to the hospital was based upon the demonstration of significant tuberculous disease either in the chest film or upon physical examination. Most of these patients presented clear evidence of clinical illness. Diagnoses were confirmed by biopsy, culture methods or by differential clinical study. Seventy-two patients presented unmistakable pulmonary disease. Eleven of the 34 right-sided lesions were the result of bronchial obstruction, 19 patients presented bilateral infiltrations and cavitations were demonstrable in a considerable number. Tuberculous pleuritis in eight patients with so-called "primary" disease is also noteworthy.

Almost 20 per cent of the children discharged had, in association with other tuberculosis, enlargement of superficial lymph nodes, the diagnosis of which was confirmed by biopsy. In the five children in whom tonsillectomy and adenoidectomy were performed, two were found to have tuberculosis of these tissues.

Children with tuberculous osteoarthritis are usually sent to the orthopedic services and in this series there were only seven children in this category. Two patients who have been treated with protracted courses of isoniazid-PAS are of interest. They had received little fixation, immobilization, or prevention of weight bearing, but one, an infant with tuberculosis of the tibia and knee joint, now has a complete range of motion. The other, a six-year old Negro boy with severe Pott's disease and a large abscess of the thigh, has little deformity and no residual abscess.

Miliary tuberculosis and tuberculous meningitis have received considerable notice recently. In this series miliary tuberculosis was limited to six children of less than two years. Of the 21 patients with tuberculous meningitis, six had no other demonstrable tuberculous disease. Our findings parallel those of others which indicate that the younger the child, the higher the incidence of meningitis and miliary tuberculosis, and the worse the outlook for recovery.

Approximately two years ago, it was decided to establish a basic drug regimen for all children. This consists of isoniazid, 4 mg. per kg., and PAS, 200 mg. per kg. per day, with both drugs administered at least one year. In children with either miliary or meningeal infections, the practice had been to increase the dose of isoniazid to 10 mg. per kg. for the first two weeks and to give streptomycin-PAS as well. This triple-drug therapy has been continued for at least 18 months after the cerebrospinal fluid is normal.

For the last four years all children with tuberculosis of the superficial lymph nodes have received radiation therapy in addition to chemotherapy except those whose nodes were com-

pletely removed and those who could not be moved to the therapy unit. It is the impression that nodes regressed in size more rapidly with radiation therapy plus drugs than with drugs alone. Radiation therapy has not been used in instances of tuberculosis of mediastinal nodes, nor as the sole means of treatment.

The treatment of osseous disease consists of isoniazid-PAS in the basic dosage given above. If abscesses are present, they are drained surgically. Thoracic surgery has been necessary in 3 cases. Two resections were performed for residual cavitation and one for persistently collapsed middle lobe with bronchial disease. The procedures were tolerated very well. No collapse measures have been used.

The most striking difference between this group of sick children and those who have no evidence of tuberculosis other than a positive reaction to tuberculin is the fact that the former usually had had massive and intimate contact. This suggests that in early life the size of the infecting dose is probably of prime importance in development of disease, while the age of the child is the most important determinant of the outcome. The duration of the disease and the condition of the child at the time of hospital admission are also important. Half of the mortality occurred within 30 days of admission. In the future the drug resistance of the tubercle bacilli may prove equally significant.

The widespread distribution of disease in both lungs in 20 per cent of this series and the occasional occurrence of tuberculosis in the tonsils would apparently point to several sites of invasion. The possibility of direct invasion through bronchial and bronchiolar walls as well as at the alveolar level has to be recognized. In this series 12 patients exhibited massive mediastinal adenopathy without apparent pulmonary infiltration.

Tuberculosis of the superficial lymph nodes is not infrequent in the early age groups. Tuberculosis of the cervical lymph nodes may be the result of drainage from tonsils. The fact that in some cases the tonsils are not diseased suggests that other routes such as through the paratarcheal nodes are important. Present knowledge of lymphatic drainage would tend to incriminate the pleura as the source of infection for the axillary groups.

The repeated occurrence of pulmonary necrosis in what seems to be the sites of invasion, the development of superficial implantation type of bronchitis, and the occurrence of effusions, seem to indicate that any effort to divide tuberculosis into primary and secondary types is essentially meaningless. To one who has been familiar with tuberculosis in adults, the most striking differences consist of the location of the disease within the lung, the presence of disease of the mediastinal nodes, the tendency toward hematogenous dissemination, and the rather striking degree of recovery. One feature of generalized tuberculosis in early life is the absence of renal disease. In the present series, in spite of most careful search, no case of renal disease was discovered.

The remarkable outcome of isoniazid therapy in the two cases of osseous tuberculosis calls for a reconsideration of the methods of management. If it is possible to preserve the function of a major joint, such as the knee, and to avoid fixation without jeopardizing the patient's future welfare, it is most advisable to study this more extensively.

Radiation therapy in itself has proved to be quite effective over short-period follow-up in the treatment of superficial lymph nodes. Nevertheless, the young child, in the face of a high probability of dissemination, requires every possible prophylaxis against hematogenous seeding. This can best be accomplished by the use of isoniazid-PAS. The drainage of tuberculous pus and the removal of tuberculous necrotic material whenever it is feasible and safe, is the major desiratum. The treatment chosen consists basically of chemotherapy; to this is added excision of nodes when they are accessible and limited in number, the free drainage of pus when the nodes are fluctuant, and the application of radiation therapy when the nodes are multiple or when palpable masses persist after drainage.

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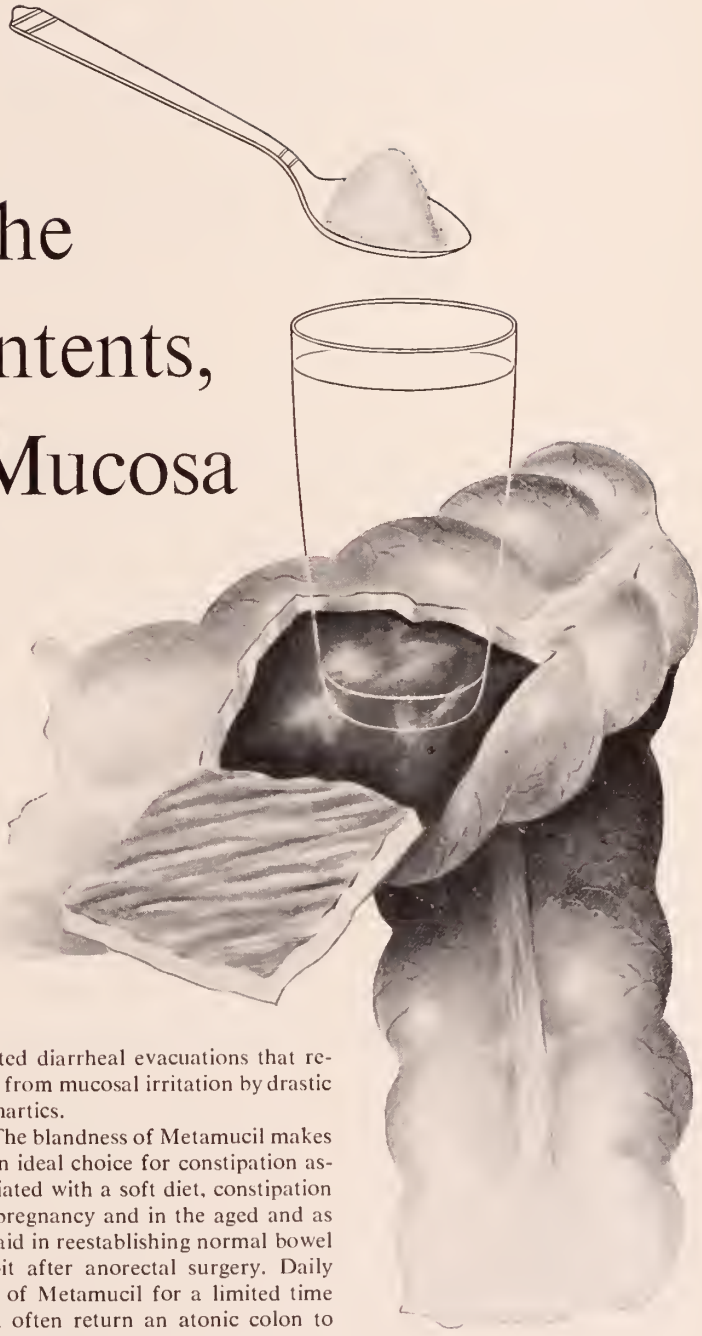
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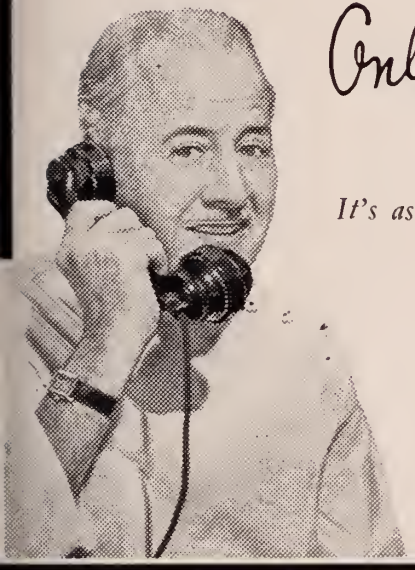
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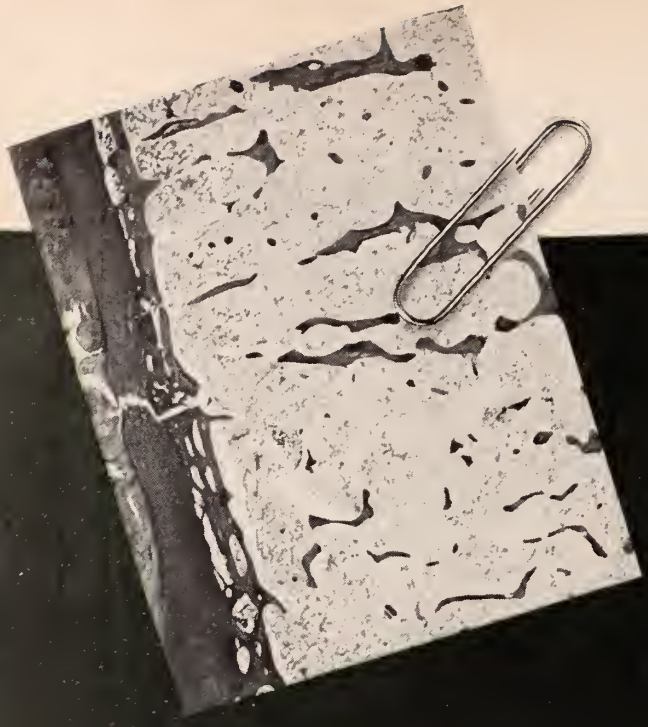
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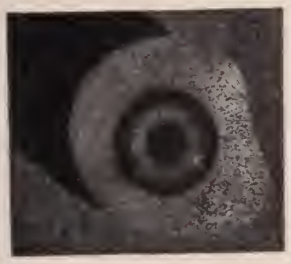
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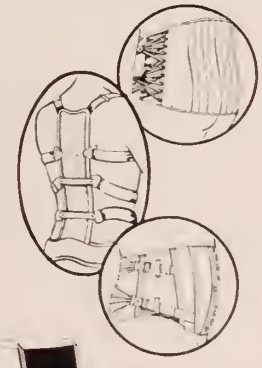
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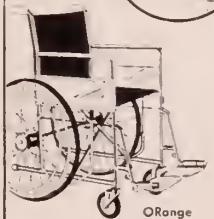
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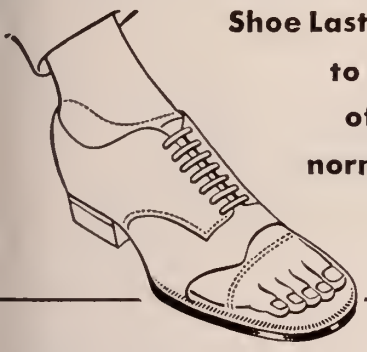


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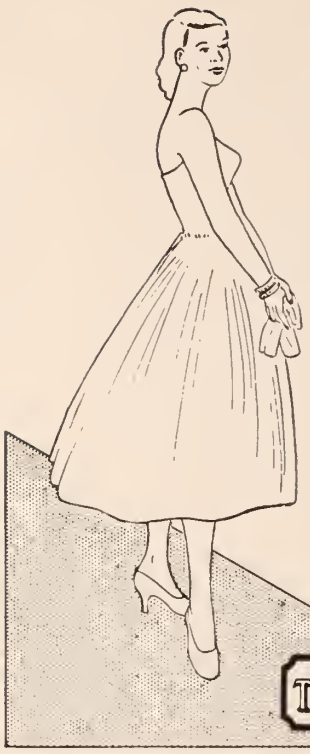
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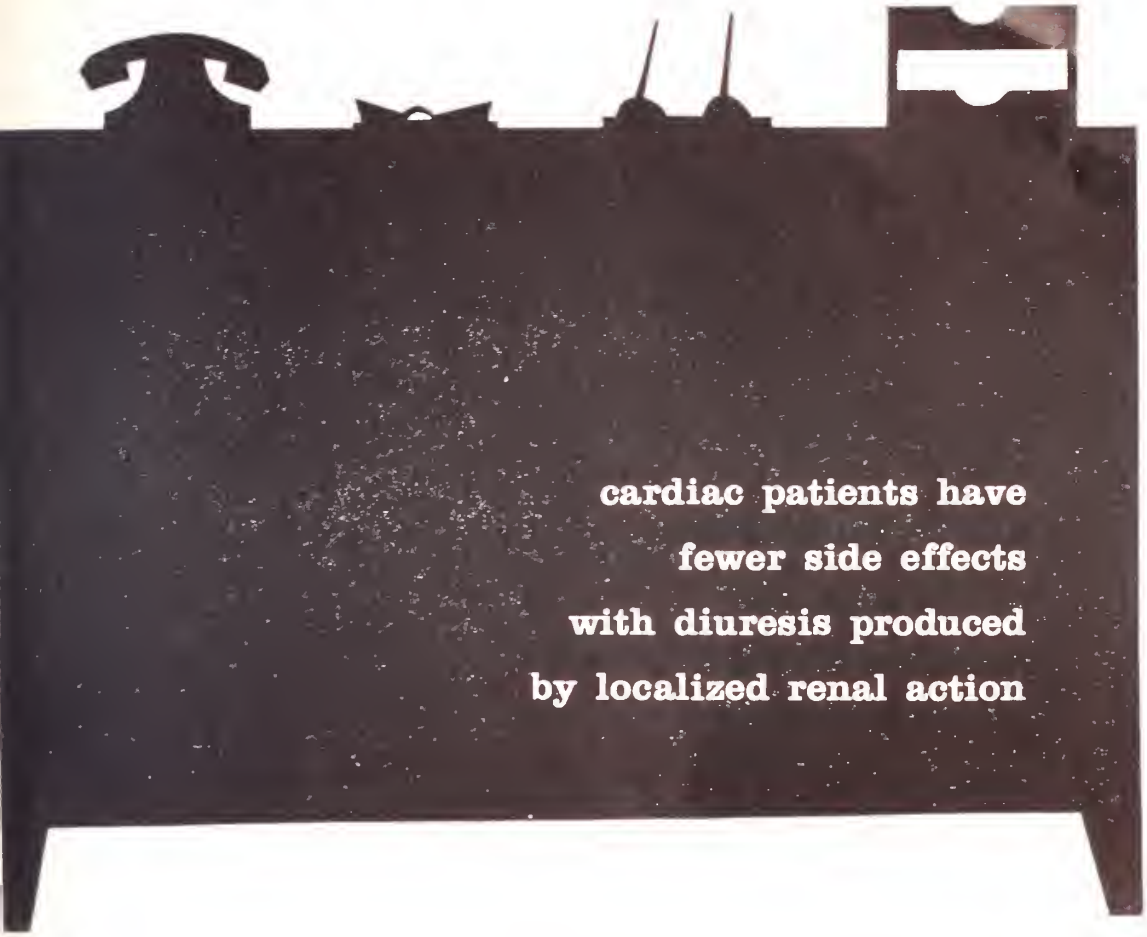
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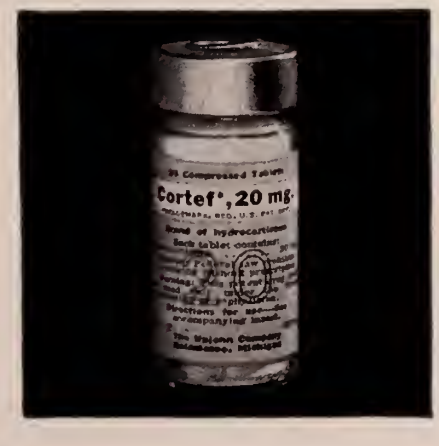
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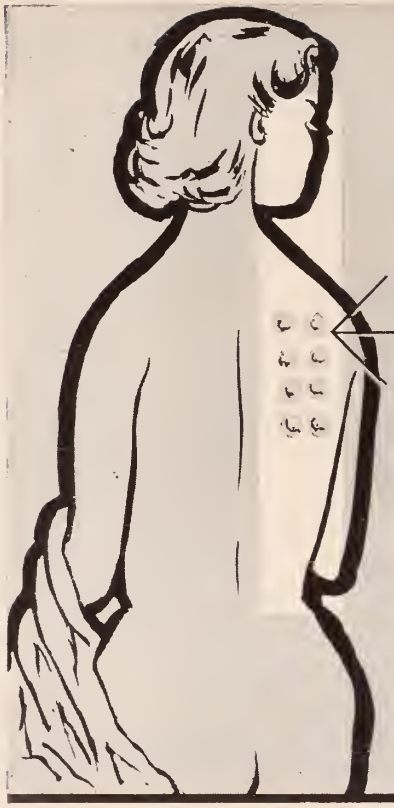
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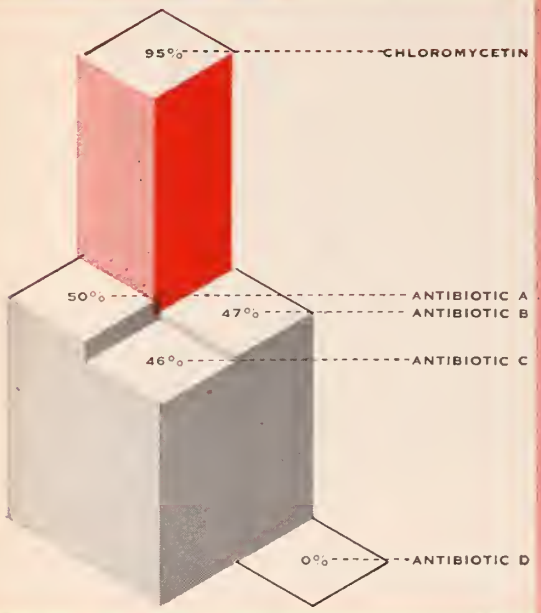
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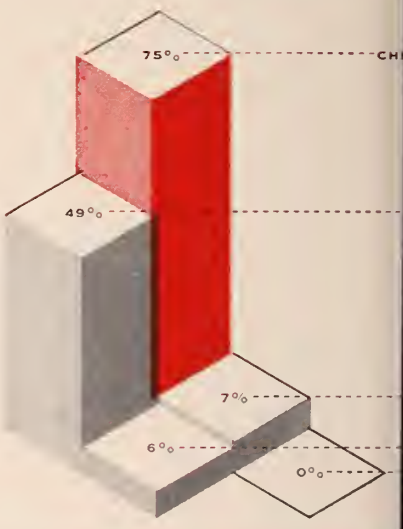
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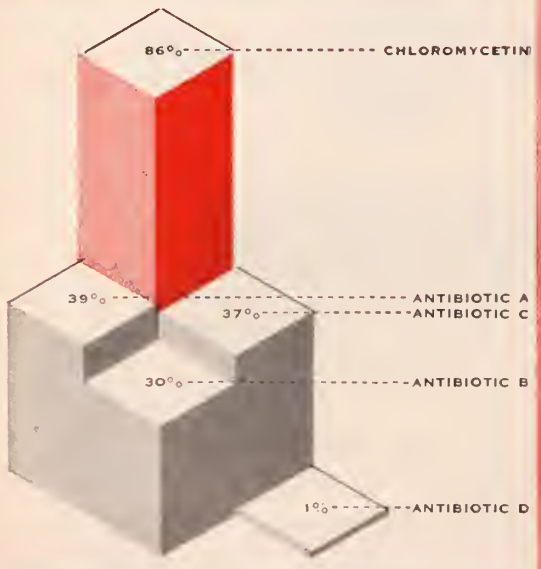


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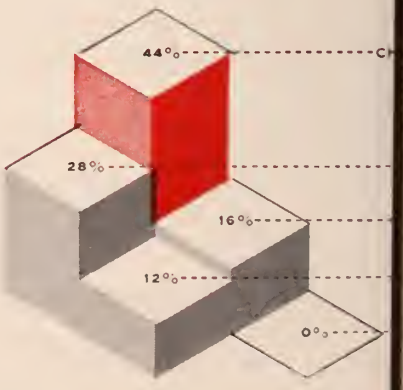


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The 190th Annual Meeting

OF

THE MEDICAL SOCIETY OF NEW JERSEY

Haddon Hall, Atlantic City, New Jersey, May 12, 13, 14, 15, and 16, 1956

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HOUSE OF DELEGATES
SESSION I
Saturday Afternoon, May 12, 1956

The One Hundred Ninetieth Annual Meeting of the House of Delegates of The Medical Society of New Jersey convened at Haddon Hall, Atlantic City, at 2:45 p.m., Dr. Vincent P. Butler, President of the Society, presiding.

PRESIDENT BUTLER: Members of the House of Delegates: The 190th Annual Meeting of The Medical Society of New Jersey is now in session. To call down Divine blessings on our proceedings, I ask the Very Reverend Monsignor Alfred W. Jess, who is the Director of Catholic Charities and Catholic Hospitals in the Diocese of Camden, to pronounce the invocation.

(Monsignor Jess then pronounced the invocation.)

PRESIDENT BUTLER: Mr. Secretary, is there a quorum present?

SECRETARY GREIFINGER: Mr. President, there is a quorum.

PRESIDENT BUTLER: Members of the House of Delegates: According to the By-Laws, the President "shall deliver an address at the Annual Meeting and shall perform such other duties as custom and parliamentary usage may require."

Looking back through the years we find that some of the most scholarly dissertations have been given as presidential addresses. One which particularly intrigued me was given in 1901 by a former president, also from Jersey City, Dr. John McGill, whose topic was "The Medico-Legal Expert." Much of what is contained in Dr. McGill's address is still very pertinent. Obviously many of the suggested procedures for improving medical testimony have not been carried out very successfully. Parenthetically, we are still wrestling with the problem. But we think we are on the road to an ultimate and effective solution. Since the close of this morning's meeting of the Board of Trustees, I have been informed that the New Jersey Bar Association, which is finishing its annual meeting here in Atlantic City, today adopted a resolution, identical with one being introduced in this House, authorizing a joint committee of the New Jersey Bar Association and The Medical Society of New Jersey, to be available to determine the merits of alleged malpractice cases submitted to it, on a voluntary basis, for evaluation.

It seems to me now that custom requires not so much an address on any specific subject or stated topic, but rather a report be given on the status of the society. In the President's report which all of you have received I have already dealt with most of the matters in detail. My remarks today are supplementary to those which I have made in my report.

I should like first to take the opportunity most sincerely to thank all the members of The Medical Society of New Jersey for the honor that they have done me in choosing me to preside over their destinies during this past year. I trust that I have in some degree measured up to their expectations. Certainly whatever has been accomplished could not have been done without the loyal support and cooperation of the officers, trustees, delegates, and members of the Society. Over and above all this I have enjoyed the assistance which has been so readily given by the Executive Officer, the Administrative Secretary and all the members of the staff. For all these things I am especially grateful. Without assistance from so many people given so willingly, this Society and I, as its President, could not have hoped for or attained any of the results that through the year have been brought about.

I should like to bring you up-to-date on the status of things by mentioning one or two items of concern that have developed or have been dealt with since the writing of my President's report.

At the request of the American Medical Association, we conducted a poll of our membership to ascertain their opinion of the extension of Social Security to include physicians on a compulsory basis. The results are in, and while they are definite they are not, to my mind, what you could call decisive. Six thousand and sixty ballots were mailed to our members; 3,433 were returned as of May 10. The ratio of returns was, therefore, 57 per cent. Of the 3,433 returned ballots, 1,543 favored the extension of Social Security, and 1,869 opposed such extension. These results are being submitted, as of today, to the American Medical Association.

During the last week in April, your officers held an important conference with the Commissioner of Health and other departmental representatives, concerning Salk vaccine. Our primary purpose in meeting with the Commissioner was to record officially the dissatisfaction of our members of their inability to obtain sufficient vaccine to impart immunity to the eligible people of the state. We took occasion to reaffirm our determination to see to

it that all eligible people of New Jersey enjoy and have equal access to the means of immunization. We stressed the fact that from the beginning we of The Medical Society of New Jersey have pledged ourselves to see to it that no one who is eligible is denied vaccination because of the inability to pay. We also stressed the necessity of so distributing the available vaccine that *all* eligible people are equally and equitably dealt with and considered. Furthermore, we emphasized that while doctors could not obtain adequate supplies of the vaccine to administer they should not and would not accept the responsibility concerning those eligible people for whom no vaccine has been provided.

As the result of extended discussion, it became evident that the chief factor accountable for the trouble in the distribution of the vaccine was the constant critical shortage of that vaccine. At no time thus far has there been enough vaccine to make it freely available. The Commissioner gave us assurance that the supply would be ample to supply first inoculations for all New Jersey eligibles, well in advance of the so-called "polio season." The Commissioner expects that with the coming of vacation time the public clinics will decrease because of the difficulty of operating them with the schools closed and the children scattered.

In view of all the foregoing we came away with the feeling that our position is clear to the Department of Health and that, if the supply increases as expected and developments are such as the Commissioner predicts, before the beginning of summer we will be able to effect the immunization of all those who are eligible for it.

I have been rather impressed with the number of amendments proposed to the Constitution and By-Laws. And, as a matter of fact, during my service as an officer of the Society, I have, again and again, been of the opinion that we must give detailed study and attention to a thorough review of the entirety of the Constitution and By-Laws. Certain matters are of such pressing import, as the revision of the By-Laws affecting the judicial mechanism, that action concerning them must not be postponed, but I would suggest to this House that it consider the timeliness and desirability of effecting a complete study of the Constitution and By-Laws with a view to making at one time complete and effective necessary revisions.

It has been for me a year of activity and occasionally of rather exhausting effort. But it has been a year that I am delighted in, not so much for the honors that it brought me but for the intimacy of the contacts into which it brought me with so many of you. I have learned much of the problems of medicine but of this truth I am convinced, none of them are insuperable so long as we meet them sincerely, willingly and courageously, and so long as we meet them together.

And now, may I ask for a report from the Committee on Credentials?

DR. JEROME KAUFMAN: As of 2:25 p.m. today, 169 Delegates were registered.

PRESIDENT BUTLER: Thank you, Dr. Kaufman.

Some important matters came before the House of Delegates last year. Because of some of the difficulty that ensued, with the way in which they were carried out, we have decided this year that we will try to have as little difficulty along those lines as possible. It is therefore my pleasure to announce that at this time we have appointed an official Parliamentarian who will be present at our meetings and Reference Committees, if necessary; and at this time I announce the appointment here of Mr. Joseph T. Karcher, the official Parliamentarian of the New Jersey State Bar Association. Mr. Karcher is from Sayreville, New Jersey. Mr. Karcher. (Applause)

I also announce the appointment of Dr. Benjamin F. Lee of Camden, and Dr. George A. Corio of Trenton as Sergeants-at-Arms.

DR. GRAHAM C. NEWBURY (Union): Mr. Chairman, we have a question on the organization of these Reference Committees. Could we present it at this time?

PRESIDENT BUTLER: All right, what is your question?

DR. NEWBURY: The question is on the validity of Reference Committees.

PRESIDENT BUTLER: I refer that to the Parliamentarian.

THE PARLIAMENTARIAN: I think you should follow the order here that is printed. I don't think that this is the proper time. What number are you on now, on 3 or 4?

DR. NEWBURY: You are under Organization, aren't you?

PRESIDENT BUTLER: Yes, of the House of Delegates; that is correct.

DR. NEWBURY: Well, that's our question on the organization of the Reference Committees.

PRESIDENT BUTLER: And the House has a right to adopt rules of its own organization is that what you are assuming?

DR. NEWBURY: We want to try to establish the validity of the Reference Committee on Constitution and By-Laws.

PRESIDENT BUTLER: As it relates to the establishment of the Reference Committees of the Society, is that what your question is?

In my opinion, this is a matter for the Reference Committee on Constitution and By-Laws.

DR. NEWBURY: You can't send it to the Reference Committee if you don't know what the Reference Committee is supposed to do. We want to establish what the Reference Committee is supposed to do.

THE PARLIAMENTARIAN: Mr. President, if you are under Organization, why don't you discover what the problem is and see whether it is appropriate at this time. If it can be referred to the Reference Committee, do it; if it can't be, dispose of it now.

PRESIDENT BUTLER: All right, then that request is in order.

DR. NEWBURY: We want to bring out this question of the function and validity of the Reference Committee on Constitution and By-Laws because last year the Board of Trustees after the meeting of the House of Delegates set up a special super-Committee on Constitution and By-Laws which it gave definite or certain powers.

Now, the question in our mind is what is the function of this Reference Committee and what interpretation we can find in the Constitution as to what this Committee is supposed to do. We feel that that can be settled by an amendment or motion stating the House of Delegates' interpretation of the Reference Committee and the committees referred to in the amendments under the Constitution and under the By-Laws. The Union County delegation wishes to present the following motion in regard to the organization and validity of Reference Committees:

We move that the Reference Committee referred to in Chapter VIII, Section 15 of the By-Laws, entitled "Names of Reference Committees," under "(c) Constitution and By-Laws:" and the Committee in Article 12 of the Constitution, entitled "Amendments," referred to as the "Committee on Revision of Constitution and By-Laws:" and the Committee in Chapter XV of the By-Laws, entitled "Amendments," and referred to as the "Committee on Constitution and By-Laws" be considered to be as one and the same Committee by the House of Delegates. In other words, the three Committees referred to, one under Reference Committees, one under amendments to the By-Laws and one under amendments to the Constitution, and our motion is that these three references be considered to be one and the same committee.

(The motion was seconded.)

PRESIDENT BUTLER: I'm very glad we have our Parliamentarian here.

Would this not in effect, Doctor, eliminate the other Reference Committees that have already been appointed and have them now have to be reappointed? Would that not do so?

DR. NEWBURY: You have already appointed a Reference Committee on Constitution and By-Laws. That Committee would not be eliminated. This would eliminate the special committee which was appointed by the Board of Trustees last year.

PRESIDENT BUTLER: Well, that goes out of effect with the present Board of Trustees. It was only effective for use by this present Board.

DR. NEWBURY: You declared the action of the House of Delegates invalid last year because it did not go to this special Reference Committee.

PRESIDENT BUTLER: But it did go to a Reference Committee. It went to a Special Reference Committee.

DR. NEWBURY: It went to the Reference Committee on Constitution and By-Laws. Later, if I interpret it correctly, you sent out a letter and you stated that that action and those two amendments were invalid.

PRESIDENT BUTLER: Because they had not previously been presented to the Committee on Constitution and By-Laws. But that was not the real reason that it was thrown out.

DR. NEWBURY: That was one of the reasons.

PRESIDENT BUTLER: Pardon me. That may be *your* reason, but the reason that the Board of Trustees decided that it was invalid was because the Reference Committee took unto themselves a function which, on the advice of legal counsel, was not within their authority. They changed the whole content of the amendment which was referred to them and therefore the Board of Trustees merely acted as the governing body between the meetings of the House of Delegates. They acted on the advice of counsel that what had transpired in the House of Delegates was not a proper action by the Reference Committee because of two facts: one was that it had not previously been reported to the Constitution and By-Laws Committee. The second reason was that it substantially changed the amendment which was presented to them.

DR. NEWBURY: Mr. Chairman, the point I'm bringing up is in regard to your first instance. We want to get this settled as to what function this Reference Committee has. This is the only Reference Committee referred to in the Constitution and you have set up another special committee which supersedes this committee referred to in the Constitution. Our contention is that this Reference Committee is the proper and correct committee to which these amendments should be referred; and that is the purpose of this motion, to clarify this and to have all this action take place here at the meeting of the House of Delegates and

not by some super committee set up at a later date.

PRESIDENT BUTLER: This was no super committee, I assure you, Doctor, set up at a later date. It was set up with the idea that it would conform with the requirement to have a committee to which amendments to the Constitution and By-Laws could be presented. That is what was set up by the Trustees this last year. They received all of the proposed amendments to the Constitution and By-Laws. They were not empowered to change them substantially. Their job was merely to see if they were in conformity as to verbiage and as to their content, to be presented to the House of Delegates.

DR. NEWBURY: Our contention is that this committee is not necessary. The Reference Committee is the only necessary committee. That is the purpose and intent of this motion: that the Reference Committee here established in the Constitution is the one and only committee which is necessary to process these amendments.

PRESIDENT BUTLER: Well, then, according to that, if the Reference Committee was not appointed until the Annual Meeting, how would it be possible to conform to the Constitution and By-Laws by having those amendments presented to such a committee *before* the House of Delegates met?

DR. NEWBURY: It's not necessary. That's to be done in Reference Committees. That's what your Reference Committee is for. Any one of these component county societies can propose an amendment. There is no reason why it should be censored or edited by a special committee.

PRESIDENT BUTLER: Except that the provisions of the By-Laws are that it should be submitted to the Committee on Constitution and By-Laws. That's the only reason it is submitted. Now please restate your motion.

THE PARLIAMENTARIAN: May I inquire as to the exact purpose of this motion? My understanding is that the Reference Committee that you are trying to give validity to, that their term has expired; that you are questioning the validity of the new committee that has been appointed by the President, by mail?

DR. NEWBURY: There *is* a Reference Committee on Constitution and By-Laws.

THE PARLIAMENTARIAN: May I ask you a question? Is there a standing committee that is officially in office?

DR. NEWBURY: Yes.

THE PARLIAMENTARIAN: And a second one has been appointed by the President?

DR. NEWBURY: A special committee was appointed last year. We are talking now about the action of last year in which two amendments went through the Reference Committee on Constitution and By-Laws. Dr. Butler just told you the Board of Trustees declared these actions invalid on the first count because it had not previously been submitted to a special Committee on Constitution and By-Laws although it had gone to the regular Standing Committee on Constitution and By-Laws. Now, in the Constitution there are three committees; one is this Reference Committee. I am trying to clarify the thing and declare that the three committees referred to in the Constitution—one under Reference Committees, one under the amendments to the Constitution and one under the amendments to the By-Laws—are all one and the same committee. I made a motion. I'd like to see it passed. If you will tell us we can vote on it.

THE PARLIAMENTARIAN: Certainly if it's been seconded, it's open to debate.

PRESIDENT BUTLER: There is a motion in effect, to make the three committees, the Reference Committee on Constitution and By-Laws, the special committee which has been formed to receive amendments to the Constitution and By-Laws—and what other committee?

DR. NEWBURY: The special committee isn't involved in this. My purpose is to eliminate the special committee as such. The special committee has a place. It is proper to look over the amendments and offer suggestions, but not as part of the valid function of constitutional procedure.

THE PARLIAMENTARIAN: You wish the standing committees to take over the functions so far as actually formulating the amendments to the Constitution and By-Laws, is that correct?

DR. NEWBURY: That's the motion.

DR. ROYAL A. SCHAAF: Mr. Chairman and Members of the House of Delegates: It is not clear in my mind exactly what the Doctor is trying to accomplish. The Reference Committee which sat in the House of Delegates last year expired with that convention. Subsequently, upon advice of counsel, the Board of Trustees, acting in the interim for the House of Delegates, found it necessary to invalidate certain recommendations that had been made by the House of Delegates, on the ground of questionable legality. Therefore, a special committee was appointed, of which I happened to be Chairman. The other members were Dr. McCall and Dr. Lance. All of these proposed changes were referred to us. There were certain changes relating to the Judicial Council which we reviewed and there were certain minor changes which were necessary. We of-

fered those to the Judicial Council for their acceptance. The Judicial Council approved them. They came to the House, being referred to the appropriate Reference Committee with the recommendation that they be approved.

These other proposed changes in the Constitution and By-Laws related mostly to the Board of Trustees, and your Board and your Trustees' Committee who were empowered to review these proposed changes felt that there might be an impropriety in members of the Board passing on proposals which would change the character of the Board. For that reason the committee recommended that all of the proposed changes relating to the structure of the Board of Trustees be referred to the present Reference Committee in this convention for determination, without recommendation.

There were two or three defects in the proposed changes, which in turn were referred back to the respective county societies—I think they related both to Mercer and Union County proposals. The defects were indicated. Subsequently the defects were corrected and those corrections were in turn directed to be transmitted by the Trustees to the House of Delegates.

At the present moment there is only one functioning committee and that is the duly and properly appointed Reference Committee of this House of Delegates. There can be no question about the legality of that committee. I think that they will start, as the lawyers say, *de novo* and consider these proposed amendments. This House will have a chance to vote on the recommendations of that Committee at its third session. This argument looks to me like a tempest in a teapot.

DR. NATHAN S. DEUTSCH (Union): The broader scope of this thing is the function of Reference Committees. What do their duties encompass? What effect do they have on the House of Delegates when the House of Delegates passes one of these motions? Can the Board of Trustees itself overrule the House of Delegates? I think we have three questions to consider.

PRESIDENT BUTLER: In the past this was sent to all the members of the Reference Committees. It's too long to read here, but certainly anyone who has any doubt about the function of the Reference Committee would be very much enlightened by reading this letter which is sent to each member of the Reference Committee. So I don't think there would be any question in their mind as to what their function was.

DR. DEUTSCH: We have a duly appointed Reference Committee on Constitution and By-Laws. Obviously their work is to work on anything that has to do with the Constitution and By-Laws.

PRESIDENT BUTLER: That is referred to them from the House of Delegates, yes.

DR. DEUTSCH: Let's take it one step from there. I mean the results of their work as it comes from the Reference Committee from discussion and so to bringing their recommendations to the House of Delegates and the House of Delegates vote on it. Can some other body change that by itself?

PRESIDENT BUTLER: I will answer that in my own way and see if the Parliamentarian sustains me. If it has been decided by the legal counsel that action was completely contrary to the Constitution and By-Laws and in effect it was what he called a nugatory action, was not then the Board of Trustees perfectly justified in their action in negating?

THE PARLIAMENTARIAN: I would say there is no question about it; you have a right to rely on counsel that represents you.

DR. DEUTSCH: That was on the first or second points, but the first point you said it wasn't referred to the proper committee and it was reviewed by this other committee that was set up. How about that?

PRESIDENT BUTLER: The assumption was that it had not been referred to a previously appointed Committee on Constitution and By-Laws to which all Constitution and By-Laws amendments should have been referred.

DR. NEWBURY: The first thing I can't quite understand is why any lawyer would have the right to overrule any action of the House of Delegates.

PRESIDENT BUTLER: Pardon me, Doctor Whether you can understand it or not, the Parliamentarian has so decided and as far as I'm concerned that's the ruling of the Chair and it has been decided.

DR. NEWBURY: Well, we can appeal the ruling of the Parliamentarian. And if that's the ruling of the Parliamentarian, then I appeal it, but this is outside the motion that we are talking about at the present time.

You stated that there had been a Reference Committee appointed at this present session, that we were going to start in again anew. There was a reference committee appointed last year, too, which started all over from new. After that committee was appointed you again brought in another committee, a special committee that has no source in the Constitution. By that action you overuled the action of the Reference Committee and the House of Delegates simply because the amendments were not referred to this special committee which you set up.

PRESIDENT BUTLER: Well, I think you are

entirely incorrect in that. There is provision in the By-Laws for the special Committee on Constitution and By-Laws which was put into being.

DR. SCHAAF: May I offer a motion to sustain the ruling of the Chair?

(The motion was seconded.)

PRESIDENT BUTLER: Regularly moved and seconded that the Chair be sustained in such a ruling.

DR. NEWBURY: I object. There is a motion on the floor. My motion is on the floor. You discussed another point entirely and now he has made a motion on it.

THE PARLIAMENTARIAN: This is getting very complicated, quite unnecessarily, too. The doctor who has brought this up says he appeals from your ruling. Dr. Schaaf moved to sustain your ruling. If that is carried the thing is settled and it is over. Get the wishes of the House and get it over with.

DR. ASHER YAGUDA: I second it.

PRESIDENT BUTLER: The motion to sustain my ruling certainly is in order, I call for a vote on it.

A DELEGATE: I would like to ask one question. It seem to me Dr. Schaaf said that we are stirring up a tempest in a teapot. May I ask you sir, why, since you felt that the action of the Reference Committee on By-Laws was inappropriate, why did you not refer it back to that Reference Committee for correction? Why did you set up another committee?

THE PARLIAMENTARIAN: It is not debatable. You don't have to answer it.

PRESIDENT BUTLER: I would like very much to answer your question, Doctor, but it is not debatable.

A DELEGATE: I wish you would answer the question. That is not debate; it is merely asking.

PRESIDENT BUTLER: I will as soon as we take a vote on the motion to sustain the Chair.

A DELEGATE: A point of order on the consideration of this motion to sustain. Is this sustaining an action of the Board of Trustees and is this the time for it to come up?

THE PARLIAMENTARIAN: The question is sustaining the ruling of the Chair that the action they have previously taken was on the advice of counsel and it disposes of the motion of the Doctor from Union, so that you can get down to the work of today. If his motion were to prevail, the reading of these amendments last year would have been legal even in the face of a legal opinion to the contrary. And so that all of this is involved in the Doctor's motion to sustain the action of the Chair, to determine that this doctor from Union is out of order so that you can proceed with the rest of the business. Otherwise you will be here all afternoon and certainly will be a tempest in a teapot.

PRESIDENT BUTLER: I will call for a vote on the motion, on the motion to sustain the Chair on my ruling. All those in favor will please rise.

(Some Delegates arose.)

Opposed.

(Some Delegates arose.)

The Chair is sustained, and we can proceed with the business of the day.

The next order of business concerns the *Transactions* of the 1955 Annual Meeting.

DR. JEROME KAUFMAN: I move that we approve the *Transactions* of the 1955 Annual Meeting of the House of Delegates as published as a supplement to the September 1955 JOURNAL and distributed to all of the members.

DR. DEUTSCH: Will that delete the actions of the Reference Committee on Constitution and By-Laws?

PRESIDENT BUTLER: The action of the House of Delegates at its annual meeting was published as a supplement to the 1955 JOURNAL and you all have had a copy of that. The *Transactions* contained all of the actions that were properly carried on. Do I hear a second?

(The motion was seconded.)

PRESIDENT BUTLER: Regularly moved and seconded that the *Transactions* of the annual meeting of the 1955 House of Delegates, as published as a supplement to the September 1955 JOURNAL and distributed to the membership be approved.

DR. NEWBURY: Does that mean by approving that, that the two amendments that are in controversy are also approved. There is a footnote that the Board of Trustees disapproved those two actions.

THE PARLIAMENTARIAN: It excludes anything that has been declared illegal by your counsel.

PRESIDENT BUTLER: Excluding anything which has been declared illegal by the counsel.

All those in favor of the approval signify by saying "Aye;" contrary, "No." (There were a few Noes.) Carried. Well, at least we started off good. The Parliamentarian is complaining already. (Laughter) He said he'd rather serve the lawyers. You ain't seen nothing. (Laughter)

Shortly before I came up here I saw an old friend of ours come in—I mean not old chronologically but old in association with this Society. He is a past-President of the Medical

Society of New York and a Delegate from New York to the American Medical Convention, Dr. J. Stanley Kenney. Would you mind coming up and saying a few words? (Applause)

DR. J. STANLEY KENNEY: Dr. Butler, Dr. Fritts, other Officers of the New Jersey Medical Society, Ladies and Gentlemen of the House: You made me feel very much at home almost immediately, not only by your generous welcome, but by the debate that I have just listened to because we hear that not infrequently in the councils of the Medical Society of the State of New York.

It is always a great pleasure personally to me to come to the New Jersey meeting. I have been coming for a great many years. As I said on many occasions, I feel sort of part of New Jersey, having lived in this state a long while and received all my education prior to medical college in New Jersey.

We just had a strenuous session in New York, a five-day convention which only terminated at noon yesterday. The sessions were long and heated at times. Most of us, including myself, are pretty fatigued.

The one man that through the convention listened very seriously, as much as anybody that was part of the New York delegation, was your Delegate from this state. I must say that you should feel very proud of Bill Costello. He took a very interested and active part in our convention. (Applause)

New York and New Jersey and our sister states of Pennsylvania and Connecticut have many things in common. I hope that some day there will be some way that, on some of the more difficult problems, we can have uniform action. I don't know how we are going to attain it. As I sit through the discussions for years in our state on such topics as malpractice defense, the difficulty with Blue Shield, and many problems that come before grievance committees, they are so common to all of us that there ought to be some solution that isn't purely on a local level. I still hope that some day we are going to find a way here in our own area to meet these on common grounds.

A law was recently passed in New York State which will extend medical care to the Civil Service employees of the State. They number some hundred thousand. A board will be set up by the Governor. The board is going to make the decisions on how that money will be spent and how that medical care will be implemented. In the metropolitan area we have the Health Insurance Plan of Greater New York. This is a controversial subject and the mechanisms by which that organization implements medical care are very apt. You proceed north of the city line and you get out on a state-wide basis.

We should be alerted to this type of practice. There is much in that situation that you should be alerted to. I have grave misgivings about what may come out of it; how this medical care at state expense is going to be distributed.

Next February the Medical Society of the State of New York will celebrate its sesquicentennial. You gentlemen are 190 years old, so we are still in swaddling clothes. Nevertheless, we propose to hold this meeting in New York City and it will be marked by, I hope, the very special type of scientific and other programs which will be of unusual interest, and culminating with a major social function, a dinner at the Waldorf during that week. I hope as many of you as can will find time to visit us. We extend you a very hearty welcome.

On behalf of my fellow officers from the Medical Society of the State of New York, I bring you all their very cordial greetings.

Before sitting down, Dr. Butler, I would just like to say what I said last year, that I hope to be a member of the House in Chicago a month from now that will elevate to high office your distinguished representative, and I think if we can look ahead into a crystal ball, there is nothing going to stop it. Thank you very much. (Applause)

PRESIDENT BUTLER: Thank you, Dr. Kenney.

We have had a very fine liaison with our adjoining states. We send delegates and they in return send their representatives to our annual meeting. We have invited the delegates from the other states. We asked Dr. E. Tremaine Bradley and Dr. John H. Bumstead from Connecticut, but unfortunately neither of them can be here. The President of the Pennsylvania Society will be here tomorow.

Copies of the annual and supplemental reports are in the hands of the Delegates. I hope that all reports from the May JOURNAL and the mimeographed reports will be referred to the committees designated in one motion. This has been the procedure before. The committees are designated on those reports. It is in the interest of an expeditious procedure.

DR. SCHAAF: I move that the reports be referred to their designated reference committee.

PRESIDENT BUTLER: Regularly moved and seconded that the reports be referred to the designated committees. All those in favor signify by saying "Aye;" contrary, "No." So ordered.

(The motion passed.)

Are there any additional reports?

DR. SCHAAF: You all have in your hands the supplemental report from the Board of Trustees relating to the American Medical Education Foundation. This has been referred to Reference Committee "B" It reads: "The Board of Trustees recommends to the House of Delegates that The Medical Society of New Jersey make a donation to the American Medical Education Foundation and that the necessary additional assessment to cover such donation be included in the dues."

Now, I made that motion for the Trustees and the amount of $25,000 should appear after the word "donation," and I would move that that be amended to include "donation of $25,000."

PRESIDENT BUTLER: It has been moved that the Board of Trustees' supplemental report contain the additional figure of $25,000. Do I hear a second to that?

(The motion was seconded and passed.)

Resolutions received are printed or mimeographed and are included in the envelopes of the Delegates. May I have a motion referring these resolutions to the designated Reference Committees? I refer to the resolutions printed in the JOURNAL. They concern the 1955 amendments to the Constitution and By-Laws, from Union; Medical-Surgical Plan contract changes, from Mercer; income limitation on Medical-Surgical Plan, from Mercer; the Hospital Service Plan medical services, from Bergen, Camden, Essex, Hunterdon, Mercer, Monmouth, Salem, Somerset, and Union. Those have all been printed in the JOURNAL. Also, there are mimeographed reports concerning medical-legal testimony, from the Board of Trustees; and the other one concerning indigent patients in nursing homes, from the Board of Trustees. Also one concerning Hospital Service Plan from Middlesex, and one concerning medical testimony from Sussex.

May I have a motion referring these resolutions to the designated Reference Committees?

(A motion of referral was made, seconded and passed.)

Is there any new business?

DR. EDWARD G. GULLORD (Essex County): I have a resolution. Here it is:

Whereas, dissatisfaction with the new 1956 contract still exists among many physicians concerning the payment of medical fees in the Medical-Surgical Plan, and

Whereas, the payment for all medical cases on a daily fee basis is unrealistic because it does not take into consideration the various types and severity of different medical diseases, and

Whereas, there is no provision to pay medical fees for medical services required by prolonged hospitalization or for readmissions occurring within a ninety day period, and

Whereas, due to this dissatisfaction some physicians do not join and others withdraw from the Medical-Surgical Plan;

Be it therefore resolved:

That hospitalized medical cases be paid for on a fixed fee basis.

That the fixed fee be based upon the final medical diagnosis.

That maximum medical fees be limited to the same amounts as maximum surgical fees for the same patient during any contract year and follow the same schedule of maximum fees as outlined on page 1, paragraph 5 of the Medical-Surgical Plan of New Jersey.

That the Medical-Surgical Plan or other appropriate body be requested to prepare a schedule of fixed fees for medical cases based upon the final medical diagnosis.

See page 20.

DR. GULLORD: I move the acceptance of this resolution.

DR. SCHAAF: On whose behalf is this resolution introduced?

DR. GULLORD: On my own—as a Delegate.

DR. SCHAAF: A personal resolution, then?

DR. GULLORD: Yes, sir.

PRESIDENT BUTLER: If the House so wishes it will be referred to Reference Committee "C." All in favor? All opposed? Carried. This will be referred to Reference Committee "C."

DR. EDWARD G. BOURNS (Union County): I have in my hand a bottle of Salk vaccine which, within the last few weeks, was distributed to a physician in Elizabeth. Its expiration date is October 1, 1955. The doctor asked the manufacturer whether it could be used in March 1956. They said that, under no circumstances could he use the vaccine at that time. Let me read a resolution:

Whereas, the distribution of federally purchased Salk vaccine in New Jersey has been chaotic, inequitable, and capricious, and

Whereas, this has resulted in great dissatisfaction among the public and physicians of New Jersey and created much dissension therefrom, and

Whereas, the method of distribution of Salk vaccine in New Jersey as chosen by the State Department of Health has violated the principles of free economic enterprise, and resulted in outdating of urgently needed vaccine, and wasting of vaccine, and has employed a scientifically unsound method of distribution from a public health immunization point of view, and

Whereas, under this same federal law numerous states saw fit to use this very vaccine in physicians' offices legally under a ruling of the United States Public Health Service, therefore

Be it resolved, that The Medical Society of New

Jersey at its annual meeting urges the State Department of Health to:

1. Cease immediately its present method of distribution of any Salk vaccine.

2. Distribute all future Salk vaccine in accordance with the aforementioned ruling of the United States Public Health Service, which ruling clearly states that federally purchased Salk vaccine may be given in physicians' offices and that a charge may be made for this service, but that no charge may be made for the vaccine itself, and

Be it further resolved, that the House of Delegates of The Medical Society of New Jersey condemn the administrative decision of the State Department of Health which has been directly responsible for the outdating of Salk vaccine, its waste, and its inequitable and unscientific distribution, and

Be it further resolved, that the State Department of Health be asked to explain why under its chosen system of distribution, urgently needed vaccine has been withheld from the public, and

Be it further resolved, that a copy of this resolution be sent to the Governor of New Jersey, the Commissioner of Health, and the public press.

See page 21.

DR. BOURNS: I move acceptance of this resolution.

(It was seconded)

PRESIDENT BUTLER: Any comment? All in favor say "Aye." All opposed? Passed. This will be referred to Reference Committee "E."

DR. F. PARKER WILLEY (Essex County): The following resolution has been prepared by Dr. Herman Tillis and myself. Dr. Tillis represents the New Jersey chapter of the Arthritis and Rheumatism Foundation. Here is our text:

Whereas, the New Jersey Chapter of the Arthritis and Rheumatism Foundation is about to engage in a general census of arthritic sufferers throughout New Jersey beginning in June 1956, and

Whereas, the information thus obtained will be invaluable in developing the program of the New Jersey Chapter of the Arthritis and Rheumatism Foundation for the relief and rehabilitation of arthritic sufferers, be it therefore

Resolved, that The Medical Society of New Jersey approve and endorse in principle the proposed census of arthritic sufferers in our state, and be it further

Resolved, that The Medical Society of New Jersey request its members to cooperate in the conduct of the census whenever possible.

See page 21.

PRESIDENT BUTLER: Regularly moved and seconded that this resolution be received. All those in favor signify by saying "Aye;" contrary, "No." This will be referred to Reference Committee "E."

The following amendments to the Constitution and By-Laws have been printed in the JOURNAL: Article VI, concerning the Board of Trustees, from Union; Article VI, concerning the Board of Trustees, from Mercer; Article XII, amendment to the Constitution and By-Laws, from Union; Chapter V, Selection of Officers, from Union; Chapter VI, Duties of Officers, from Mercer; Chapter VI, Duties of Officers, from Union; Chapter VII, Judicial Council, from Judicial Council; Chapter VII, Judicial Council, from Union; Chapter VIII, Committees, from Union; and Chapter XV, Amendments, from Union.

The mimeographed ones concern amendment to proposed amendment to Article VI, Board of Trustees, from Union through the Board of Trustees; and amendment to proposed amendment to Article VI, Board of Trustees, from Mercer through the Board of Trustees.

All of these are in your hands in the Delegates' envelopes and I would ask a motion to have the distribution of this printed material constitute the first reading. These must be read twice during the annual meeting, so if it meets with your approval what has been printed, and I consider read by you, in the JOURNAL and the mimeographed copies, I ask your approval of those as the first reading.

A DELEGATE: I so move.

(The motion was seconded.)

PRESIDENT BUTLER: Regularly moved and seconded that the publication therein be considered as the first reading of these amendments. All those in favor signify by saying "Aye;" contrary, "No." So ordered.

DR. NEWBURY: In Chapter XV, "Amendments," it states that the By-Laws have to have two readings at this time. It says that the "By-Laws shall have been submitted to the Committee on Constitution and By-Laws and shall have been read twice in open meeting and laid upon the table for one day." So I make a motion that this meeting be considered as second reading.

PRESIDENT BUTLER: We were coming to that later. Dr. Newbury is a little bit ahead of us. I think he is afraid. You can rely on me.

At this time I would seriously urge all of you to spend some time looking at our exhibits, both scientific and technical. I'm sure I don't need to remind you of who actually pays the freight for this convention, and that is our technical exhibitors. They come down here expecting us to cooperate. A little visit to their exhibits will certainly stimulate them to return and to help us to continue on the

high plane that we have been about to run this convention.

After this House of Delegates recesses there will be a discussion on the operative actions of the Medical Society. You are all asked to participate.

I now call for proposed amendments to the Constitution and By-Laws from the floor. They can be proposed now. They can be introduced this year. No action can be taken on them until next year. Are there any amendments to the Constitution and By-Laws?

Amendments should be read at this time to constitute the second reading, or with the permission of the House, action can be taken to eliminate the actual reading since copies are in the hands of the delegates.

DR. NEWBURY: I so move.

(The motion was seconded.)

PRESIDENT BUTLER: That constitutes the second reading. What is your pleasure? Regularly moved and seconded that the second reading has been completed. All those in favor signify by saying "Aye;" contrary, "No." So ordered.

There being no other business, the House adjourned at 3:50 p.m.

Following a brief recess the President called to order a session, open to the general membership, for the purpose of discussing Medical Society policies and programs. According to the plan, an open forum was to be held to permit a free discussion of the membership of any and all aspects of the Society's policies and programs, past or contemplated. The President asked for questions or discussion from the floor, but none were forthcoming. Thereupon he declared the meeting adjourned

SESSION II

Sunday Afternoon, May 13, 1956

The House of Delegates reconvened at 4:05 p.m., Dr. Butler presiding.

PRESIDENT BUTLER: The meeting will come to order. The second session of the House of Delegates is in session. Dr. Forte, may we have the report of the Reference Committee on Credentials?

DR. FRANK S. FORTE: As of 3:45 p.m.; 281 Delegates.

PRESIDENT BUTLER: Thank you, Dr. Forte. Is there a quorum present?

SECRETARY GREIFINGER: Mr. President there is a quorum present.

PRESIDENT BUTLER: I now call for the report of the Nominating Committee, Dr. Lance.

DR. ELTON W. LANCE: Mr. President, I will read the report of the Nominating Committee.

Office	*Term*	*From*		*To*		*Nominee*
President-Elect	1 year	May	1956	May	1957	Albert B. Kump, Bridgeton
First Vice-President	1 year	May	1956	May	1957	Kenneth E. Gardner, Bloomfield
Second Vice-President	1 year	May	1956	May	1957	F. Clyde Bowers, Mendham
Secretary	1 year	May	1956	May	1957	Marcus H. Greifinger, Newar
Treasurer	1 year	May	1956	May	1957	Jesse McCall, Newton
Trustees:						
2nd District	3 years	May	1956	May	1959	Luke A. Mulligan, Leonia
3rd District	3 years	May	1956	May	1959	Lloyd A. Hamilton, Lambertville
5th District	3 years	May	1956	May	1959	David B. Allman, Atlantic Cit
1st District	3 years	May	1956	May	1959	Louis S. Wegryn, Elizabeth
Councilors:						
1st District*	1 year	May	1956	May	1957	Ralph M. L. Buchanan, Phillipsburg
2nd District	3 years	May	1956	May	1959	Joseph M. Keating, Passaic
5th District	3 years	May	1956	May	1959	Isaac N. Patterson, Westvill
A.M.A. Delegates.	2 years	January	1957	December	1958	C. Byron Blaisdell, Asbury Park
	2 years	January	1957	December	1958	Vincent P. Butler, Jersey Cit
	2 years	January	1957	December	1958	L. Samuel Sica, Trenton
	2 years	January	1957	December	1958	Elmer P. Weigel, Plainfield

A.M.A. Alternates:	2 years	January	1957	December	1958	Ralph M. L. Buchanan, Phillispburg
	2 years	January	1957	December	1958	Jesse McCall, Newton
	2 years	January	1957	December	1958	Herschel Pettit, Ocean City
	2 years	January	1957	December	1958	John H. Rowland, New Brunswick
Delegates and Alternates to Other States:						
New York:						
Delegate:	1 year	1957 convention				William F. Costello, Dover
Alternate	1 year	1957 convention				Peter H. Marvel, Northfield
Connecticut:						
Delegate	1 year	1957 convention				Blackwell Sawyer, Toms River
Alternate	1 year	1957 convention				Baxter H. Timberlake, Atlantic City
Standing Committees:						
Finance and Budget	6 years	May	1956	May	1962	Joseph I. Echikson, Newark
Publication	3 years	May	1956	May	1959	C. Spencer Davison, Salem

*This is to fill Dr. Gardner's unexpired term.

DR. LANCE: I now move that this report be received.

(The motion was seconded and carried.)

PRESIDENT BUTLER: Nominations from the floor are now open. The appropriate authority is Chapter V, Section 4 of the By-Laws, which says:

"Nothing in this chapter shall be construed to prevent additional nominations being made from the floor by members of the society; except that the President-Elect shall succeed to the office of President without process of nomination and election."

It also states that: "All elections shall be by ballot, and a majority of the votes cast shall be necessary to elect."

One or two other important matters may come up. One concerns the voting of an alternate delegate.

Article IV, Section 3 (e) of the Constitution states, as far as alternates are concerned: "Each component society shall elect, at its annual meeting, an alternate delegate for each regular delegate, and the latter, if unable to attend the annual meeting of this society, shall assign his delegate's card to an alternate. An alternate, when serving shall have all the rights and privileges of a regular delegate; and when registered and seated in the House of Delegates shall retain his seat during that entire meeting."

I presume that that covers most of the points.

Nominations from the floor are now in order. Dr. Fritts becomes President of The Medical Society of New Jersey, so, of course, no nominations for President may be made. For President-Elect, the Nominating Committee has offered the name of Dr. Albert Krump of Bridgeton. Are there any nominations from the floor?

In this manner, the President called for nominations for President-Elect, both Vice-Presidents, for Secretary, Treasurer, Trustees and Councilors. There were no nominations from the floor. The House, in each instance, voted to close nominations, so that, in each instance, the candidate offered by the Nominating Committee (see previous page) was elected.

PRESIDENT BUTLER: A.M.A. Delegates, for two years. The nominee of the Nominating Committee is C. Byron Blaisdell, Asbury Park. Are there any nominations from the floor?

A DELEGATE: I move the nominations be closed and the Secretary cast the House's ballot for Dr. Blaisdell.

PRESIDENT BUTLER: All those in favor signify by saying "Aye;" contrary, "No." So ordered.

The nominee of the Nominating Committee for A.M.A. Delegate for two years, from January 1957 to December 1958, Dr. Vincent P. Butler, Jersey City. Are there any nominations from the floor?

DR. JEROME KAUFMAN: Mr. President, I wish to make a nomination.

PRESIDENT BUTLER: Yes, sir, Will you come up?

DR KAUFMAN: Mr. President, Members of the House of Delegates: As Chairman of the Essex County Delegation, I would like to place in nomination the name of Dr. J. Wallace Hurff, who has been a Delegate to the A.M.A. from our State for the past ten years.

Dr. Kaufman then delivered a nominating speech on behalf of Dr. Hurff.

President Butler: Thank you. Incidentally, Dr. Kaufman has just concluded his term as president of the Essex County Medical Society. Any other comment? I recognize Dr. Willey.

Dr. F. Parker Willey of Essex County seconded the nomination of Dr. Hurff and delivered a nominating speech on his behalf.

President Butler: Thank you Dr. Willey. Any other comment?

Dr. Joseph P. Donnelly: I would like to rise for the Hudson County delegation and say a few words about Dr. Butler.

Dr. Donnelly then delivered a talk on behalf of Dr. Butler.

President Butler: Are there any other nominations from the floor?

Hearing none I appoint a judge and two tellers. Being one of the contestants, I shall turn the Chair over to Dr. Fritts. I ask Dr. Diskan to serve as election judge, and appoint Dr. Jerome Kaufman and Dr. John Annitto as tellers. However, let us first finish the report of the Nominating Committee.

Upon motion, made, seconded and passed, all the other nominees of the Committee (as listed on previous page) were elected to their respective offices.

Secretary Greifinger: I will call the roll from here and as his name is called, let each Delegate come forward and cast his vote.

(Chorus of Noes)

President Butler: There is no choice. That's why I read for you the Constitution and By-Laws prior. Chapter V, Section 5, "Manner of Voting: All elections shall be by ballot, and a majority of the votes cast shall be necessary to elect." The conduct of the balloting, to expedite it, will be by the name of the candidate.

Dr. Newbury: We can move suspension of rules.

President Butler: The ballots will be distributed by the Sergeants-at-Arms. You write the name of your candidate on the ballot and come up here to be checked as to whether or not you are eligible to vote. What was the objection otherwise? Will the Sergeants-at-Arms distribute the ballots.

The Parliamentarian: The Secretary has raised a question as to the eligibility of delegates who will be voting. His point was merely that, as he called the roll and you came up, you identified yourself, demonstrated your eligibility to vote. You were given a ballot and you returned to the privacy of your seat, you filled out your ballot and they will be collected.

President Butler: It will expedite things if the Secretary will distribute the ballots, put the name of the nominee of your candidate of your choice on it and then come up here. There will be a box here in which it will be dropped. Before you are permitted to drop it, the Secretary will tell you whether you are eligible to vote. It's as simple as that. In other words the counties will come up as they are called because the Secretary has them listed. First I believe the order is the Fellows, the officers, and then each county as it is called; and you can be ready to come; you all know how you fit in alphabetically; when you are called be ready to come up and see if you are eligible; drop your ballot in the box, and that's it.

I will now turn the Chair over to Dr. Fritts.

Chairman Fritts: The ballots are to be distributed.

Secretary Greifinger: I want to announce that I have the names of the alternates for certain delegates up until 3:45 p.m.

(The Delegates then proceeded to vote.)

Secretary Greifinger: The Judge and Tellers report that Hurff has 149 ballots; Butler has 136 ballots. Dr. Hurff is the victor.

(The meeting was then adjourned at 5.50 p.m.)

SESSION III

Monday Morning, May 14, 1956

The House of Delegates reconvened at 10:15 a.m., Dr. Butler presiding.

PRESIDENT BUTLER: This is the third and final session of the House of Delegates. If there is any new business to be introduced during this session it must be by unanimous consent of the House. Mr. Secretary, do we have a quorum?

SECRETARY GREIFINGER: Mr. President, a quorum is present.

PRESIDENT BUTLER: Thank you. I have here a telegram from the President of The Medical Society of Pennsylvania. He will not be able to be with us. He wishes us every success here and invites all of us to the meeting of the Pennsylvania Medical Society.

At this time I will call for the reports of the Reference Committees. You received copies of those on the way in. The first report will be from Reference Committee "A".

DR. FRANK J. HUGHES (Camden): Reference Committee "A" met on May 13. Here is our report:

1. *Report of the President* — The Committee reviewed the report of the President and approved it as a whole with the exception of the section dealing with dissolution of the Welfare Committee. The Committee felt this was too vast a problem to make a definite decision, and makes the following recommendation: That this item of the report have a separate vote from the House of Delegates:

"The plan followed this year—under which the four subcommittees to the Welfare Committee were enlarged and the need for many of the advisory committees thus eliminated—has worked well. I believe it should be continued. It is, however, becoming increasingly evident that the original purpose for which the Welfare Committee was originated no longer continues to be realized. I recommend the discontinuance of the Welfare Committee and suggest that the present four subcommittees assume its function and report their findings and recommendations directly to the Board of Trustees."

Mr. President, we recommend that this consideration be given further study before any step is adopted, and I so move.

The Committee commends the President for his successful administration.

Mr. President, I move the adoption of the President's report as amended.

2. *Report of the Board of Trustees*—The report of the Board of Trustees was approved as a whole, and the Committee commends the Trustees, particularly the chairman, for the thorough investigation of the matters presented to them.

Mr. President, I move the adoption of the report of the Board of Trustees.

3. *Report of the Secretary*—The report of the Secretary was unanimously approved. The Committee recommends that in connection with the number of members being dropped for non-payment of dues, the County Societies make every effort to correct this situation.

Mr. President, I move the adoption of the Secretary's report.

4. *Report of the Judicial Council and the Councilors*—The reports of the Council and the Councilors were unanimously approved. The Committee commends the Council for its work.

Mr. President, I move the adoption of the report of the Judicial Council and Councilors.

5. *Report of the Executive Officer*—The report of the Executive Officer was unanimously approved. The Reference Committee wishes to thank the Executive Officer and re-affirms reports of previous reference committees on the work that the Executive Officer has done in demonstrating the value of the State Society to the individual members.

Mr. President, I move the adoption of the report of the Executive Officer.

6. *Resolution from the Board of Trustees Concerning the Establishment of a Joint Committee on Medical-Legal Testimony with the New Jersey State Bar Association* — The resolution was approved in spirit and intent, but the Committee disapproves the last paragraph in its present form and recommends that a committee be set up to study the problem of malpractice and invite for consultation and guidance the legal counsel of The Medical Society of New Jersey, representatives of the National Liabilities Association, our own insurance underwriter, and other recognized experts in medical-legal matters, such as Mr. Wm. P. Braun. Your Committee further recommends that when such study has been made, a report of it together with detailed plans for the construction and operation of the mechanism be submitted to the House of Delegates for its consideration and action.

Mr. President, I move the adoption of the resolution as amended.

7. *Resolution from the Sussex County Medical Society Concerning the Establishment of Codes Governing "Standards of Practice Governing Lawyers and Doctors"*—This resolution as adopted in other states is approved.

Mr. President, I move the adoption of the resolution from Sussex County.

Mr. President I move the adoption of the reference committee report as a whole.

These motions were passed and the report of Refference Committee "A" was adopted as presented.

PRESIDENT BUTLER: Now, Reference Committee "B." Dr. Schildkraut.

DR. JACOB M. SCHILDKRAUT (Mercer): Mr. President, Members of the House of Delegates: Reference Committee "B" met Sunday morning, May 13, with all members present.

1. *Report of the Treasurer*—The Committee commends the Treasurer on the fine work of the year. We recommend that the Treasurer change the government bonds into issues that are bringing better rates of interest; for example the issues of 62-67. We further recommend that the report of the Treasurer be adopted as presented.

Mr. President, I move the adoption of this portion of the report.

PRESIDENT BUTLER: Any second?

(The motion was seconded.)

DR. HENRY A. BRODKIN (Essex): I invite your attention to the disbursements in the Treasurer's report. Seven committees expend during the year less than a hundred dollars. On the other hand, four committees have expenditures approaching $4,500.

Now, we Delegates get this report and we know the expansion of the work and the necessity for these large sums of money and, of course, they are not questioned; but to discharge our responsibilities as Delegates we ought to have a breakdown of those committeers which expend $500 or more. I suggest that, beginning next year, the committees with disbursements of $500 or more provide us with a breakdown of their expenditures.

We spend $600 to have these accounts audited. But auditing is just a question of matching the vouchers against the money expended. That isn't what we want to know entirely. We would like to know just how this money is spent in the various ways that it is.

PRESIDENT BUTLER: Dr. McCall, do you care to comment?

THE TREASURER: I don't think any comment is necessary. If the House of Delegates wishes a breakdown of that type, the House of Delegates will get it, and quite readily.

DR. DAVID B. ALLMAN: Mr. President, that information is available in the report of the Finance and Budget Committee; it was available at the Reference Committee yesterday, and if Dr. Brodkin was interested he could have been there.

PRESIDENT BUTLER: That was my thinking Dr. Allman. That is always available at all times in the Reference Committee.

DR. BRODKIN: I'd like to make that in the form of a motion, Mr. President. I don't question that these reports are available and I don't like to go into committees and question these things. I think it should be an automatic thing and I'd like to make my suggestion in the form of a motion.

(The motion was seconded.)

PRESIDENT BUTLER: You want this as an amendment to the Committee report, is that correct?

DR. BRODKIN: Yes, sir, beginning next year.

PRESIDENT BUTLER: Any comments? If not, all those in favor of the adoption of the amendment as proposed by Dr. Brodkin signify by standing. Mr. Secretary, please count those voting in favor of the amendment.

THE SECRETARY: 101.

PRESIDENT BUTLER: Will those opposed stand, please?

THE SECRETARY: 101.

PRESIDENT BUTLER: The officers haven't voted. I'm voting "No." There are other angles involved. The cost which would be rather considerable. I will vote "No." So the motion as amended is lost.

What is your pleasure on the recommendation for the adoption of the report as presented originally by Dr. Schildkraut? It has already been moved that the House adopt this portion of the report of Reference Committee "B." Any second.

(The motion was seconded. Vote was then taken, and the motion, approving this part of the report, was passed.)

DR. SCHILDKRAUT (continuing the report of the Reference Committee):

2. *Report of the Publication Committee* — We are gratified with the fine report of the Publication Committee and commend the committee members and editorial staff on the report and the fine contents in The JOURNAL. We also commend the committee and staff for the excellent financial record of the publication.

We recommend that the report of the Publication Committee be adopted as presented.

Mr. President, I move the adoption of this portion of the report.

3. *Donation to American Medical Education Foundation*—The Reference Committee looked with favor upon the recommendation of the Board of Trustees that The Medical Society of New Jersey make a donation of $25,000 to the American Medical Education Foundation and that the necessary

additional assessment to cover such donation be included in the dues for 1957.

We therefore recommend that the House of Delegates approve the donation of $25,000 to the American Medical Education Foundation.

Mr. President I move the adoption of this portion of the report.

4. *Report of the Finance and Budget Committee* The Reference Committee carefully went over the proposed budget for 1956-57 and concurred with the figures submitted.

We recommend that the budget for 1956-57 be adjusted to provide for the $25,000 donation to the American Medical Education Foundation making the total budget for next year in the sum of $197,-649. Also, we recommend, since there is to be a donation to the American Medical Education Foundation, that an additional $5 be added to the 1957 dues, making the 1957 *per capita* assessment in the sum of $35.

Mr. President I move the adoption of this portion of the report.

5. *Student Loan Fund* — Reference Committee "B" carefully considered the proposal for the establishment of a Student Loan Fund and is heartily in agreement with the proposal as submitted by the Board of Trustees.

We recommend the adoption of the proposal for the establishment of this fund. We further recommend that this project be reviewed each year by the proper reference committee and changes be made as conditions demand.

Mr. President, I move the adoption of this report as a whole.

PRESIDENT BUTLER: Thank you Dr. Schildkraut. Do I hear a second? All in favor of adopting this report say "Aye." Opposed? The report is adopted. Now, Dr. Bowers, let us hear the report of Reference Committee "C."

DR. F. CLYDE BOWERS (Morris): Let me read the first three sections. I think we can dispose of them swiftly. We had a well-attended meeting. All members of the Reference Committee were present, and more than 50 other members of the Medical Society attended the hearing too. Here are the first three sections of our report:

1. *Report of the Board of Trustees regarding Hospital Service Plan* — The Reference Committtee approved this report and moves its adoption.

2. *The Annual Report of the Medical Service Administration of New Jersey*—The Reference Committee approved this report and moves its adoption.

3. *Annual Report of Medical-Surgical Plan*— The Reference Committee approved this report and moves its adoption.

Mr. President, I move the adoption of these three sections.

PRESIDENT BUTLER: Any second? Yes. All in favor? Opposed? These sections are adopted. Please proceed with your report, Dr. Bowers.

DR. BOWERS: Next we considered the changes in the Medical-Surgical contract proposed by Mercer County. Here is our report on that:

4. *Medical-Surgical Plan Contract Changes, Mercer County* — The Committee agrees in principle with this resolution; that is, dissemination of information to all levels is desirable before major changes in policy are instituted. The Committee feels, however, that the changes suggested may be inconsistent with efficient administrative operation of the plan.

The Committee moves the disapproval of this resolution.

PRESIDENT BUTLER: You have heard the motion for disapproval. Is there a second?

(The motion was seconded.)

DR. ALBERT F. MORICONI (Mercer): Mr. President, Mercer County Medical Society put this motion on the floor for action here today for a specific purpose. Consider the wording: "Resolved, that any basic change in the contract of the Medical-Surgical Plan of New Jersey be effected in the following manner . . ." Now, I want to re-emphasize that word: *basic* changes. We are not trying to interfere with the Medical-Surgical Plan. We all like it. Yet we are concerned with *basic* changes which are made without the prior approval of the House of Delegates. This House should be the governing body. Its suggestions should be followed. To protect the House of Delegates from action which might be in direct disagreement with the policy that the House of Delegates itself might adopt, we have placed this before you. Review it with me:

"Resolved, that any basic change in the contract of the Medical-Surgical Plan of New Jersey be effected in the following manner:

"1. That the details of the contemplated basic changes be in the hands of the Board of Trustees of The Medical Society of New Jersey at least three months before the meeting of the House of Delegates."

I don't think that's very unreasonable. They are the executive body that acts throughout the year. They should be made acquainted with any really basic changes that might affect the ethical conduct of the Plan, its business conduct, or other matters which might involve the medical profession as a whole. The Board is the executive body protecting us and protecting the people of the state in general against any possible changes that might not be to the benefit of the doctor or of the people.

I don't see anything particularly difficult about that. Three months isn't hamstringing anybody. As a matter of fact, before they made their final change from 1949 to 1956 it took them seven years. Now, we are not asking to take seven years to do it; we are just asking to present something three months in advance to the Board of Trustees.

"2. That a supplementary report be in the hands of the chairman of the proper reference committee and of its members one month before the Annual Meeting of The Medical Society of New Jersey."

Now, last year, I headed the Reference Committee that Dr. Bowers chaired this year. I was handed a volume of reports, supplemental reports and other things that would have taken at least a month to cull over carefully. They had taken months to prepare these reports. We of the Committee had about seven hours to figure the whole thing out and to answer questions from about 150 people. If you are going to make any real supplemental reports, certain basic changes, the Reference Committee that's to be appointed by the President, should have that in their hands 5 or 6 weeks before the meeting.

We are not asking anything unreasonable. What is wrong with the Reference Committee knowing in advance what we are going to deal with and what type of opposition we are going to have to counteract and what things should be done for the benefit of the Society itself? There is nothing wrong about that. I don't see what the objection is.

"3. That following the action of the Board of Trustees, the findings of this Board and/or the details of the contemplated basic changes in the contract of the Medical-Surgical Plan of New Jersey be published in the JOURNAL of The Medical Society of New Jersey, in the issue at least one month prior to the Annual Meeting, for the information of all the members of the Society."

Is there anything wrong about letting the members know a month in advance? I can't see how anybody can argue against this motion. We are only trying to be fair. We want to be cognizant of all the changes in something which we are vitally interested in. I can't see how anybody can really oppose it. (Applause)

DR. WILLIAM F. COSTELLO: Mr. President, in Chapter VII, Section 13 the By-Laws read: "Immediately *after* the organization of the House of Delegates at each annual meeting the President shall appoint, from the members of the House, reference committees of five members each, unless otherwise provided, to serve during the session at which they are appointed. To these committees may be referred any reports, resolutions, measures, or propositions which have been presented to the House. When a matter is referred to any such committee, it shall meet forthwith, discuss the question referred, and hear debate thereon by any interested member of the Society; and shall submit its recommendations at the next session of the House for action."

I don't see how that supplemental report can be referred to this Reference Committee a month ahead, when they are not appointed until the House convenes.

DR. MORICONI: Read the report again. You don't have to appoint the committee as of today.

PRESIDENT BUTLER: Do you care for a reading of Section 13?

DR. MORICONI: Just the portion that has to do with the appointment of the Committee.

PRESIDENT BUTLER: "Immediately after the organization of the House of Delegates at each annual meeting the President shall appoint, from the members of the House, reference committees of five members each, unless otherwise provided, to serve during the session at which they are appointed. To these committees may be referred any reports, resolutions, measures, or propositions which have been presented to the House. When a matter is referred to any such committee, it shall meet forthwith, discuss the question referred, and hear debate thereon by any interested member of the society; and shall submit its recommendations at the next session of the House for action."

DR. MORICONI: I think it is perfectly legal. I don't see what harm there would be in letting the chairman, as I'm quite sure that the President of the Society knows a long time in advance whom he is going to make his Reference Committee Chairman. He could appoint him a month beforehand and present this supplemental report to him. There is nothing secret about it, nothing illegal. Why couldn't this report be given to him in advance?

PRESIDENT BUTLER: Actually, Doctor, what happens is that you do ask certain men if they will be willing to serve on Reference Committees and you get in touch with them prior to the annual House of Delegates before they are officially appointed. To that extent I think that that might be some information which the men would be desirous of having.

Are there any other comments on the motion of the Committee to *disapprove* the resolution on the Medical-Surgical Plan contract introduced by Mercer County? If not, all those in favor of the recommendation of the Reference Committee will signify by saying "Aye;" contrary "No." The "Noes" have it and the motion is lost.

DR. MORICONI: I move the adoption of the Mercer County resolution.

(The motion was seconded.)

PRESIDENT BUTLER: Regularly moved and seconded that the Mercer County resolution be adopted. Are there any remarks?

DR. IRVING P. BORSHER: I am speaking as the Executive Vice-President and Medical Director of the Medical-Surgical Plan of New Jersey. To my knowledge the Plan has never willingly adopted any basic change in procedure insofar as policies involving The Medical Society of New Jersey are concerned—has never done this without reference, as expeditiously as was possible to the House of Delegates or, in the interim, to the Board of Trustees of the Medical Society for review and approval.

I am not certain whether the specific recommendations to this House of Delegates contained in the resolution might hamper the Plan to follow it out specifically. The Trustees of the Plan agree in principle with the intent of the resolution and I'm certain will do its best to follow out in principle. I am not sure they can actually follow that exact time-table. Remember it is not enough for the Plan to refer it to the House of Delegates or in the interim to the Board of Trustees of the Medical Society. We must also refer the proposed change to the Department of Banking and Insurance and to its subscriber groups in consultation with our enrollment agency which is the Hospital Service Plan of New Jersey.

But I'm certain that in principle the Board of Trustees of the Plan goes along with the resolution.

PRESIDENT BUTLER: Any other remarks on Dr. Moriconi's motion? If not, are you ready for the question on the approval of the Mercer County resolution? All those in favor signify by saying "Aye;" contrary, "No." The "Ayes" have it.

DR. BOWERS: May I now continue with the report of Reference Committee "C"?

5. *Apportionment of Fees by Medical-Surgical Plan, Mercer County* — The Committee feels that ample study has been made by the House of Delegates in former years and the changes suggested have been incorporated in the 1956 contract by Medical-Surgical Plan. These changes were made as the result of returns on a questionnaire in which apportionment was approved by a ratio of 7:1 of the membership of The Medical Society of New Jersey.

The Committee feels that apportionment of fees does not interfere with the freedom of the practice of medicine, since this practice is controllable at county and local levels.

The Committee therefore recommends the disapproval of this resolution.

6. *Income Limitation of Medical-Surgical Plan Contract, Mercer County*—The Reference Committee feels obliged to disapprove this resolution because the combined income limit of $7500 is the lowest amount acceptable to the Commissioner of Banking and Insurance.

7. *Hospital Service Plan Medical Services* — Resolutions from Bergen, Camden, Essex, Hudson, Hunterdon, Mercer, Middlesex, Monmouth, Salem, Somerset, Union—The Committee approves in principle the resolutions from these counties. The Committee acknowledges that pathologists, radiologists, and physiatrists are physicians engaged in the practice of medicine. In some instances some of these physicians are actually engaged in the corporate practice of medicine together with the hospitals, and as such, are practicing medicine unethically as judged by present standards of the American Medical Association.

The Committee feels that this subject should be referred by this House of Delegates to the Board of Trustees of The Medical Society of New Jersey, with the recommendation that immediate and definite steps be taken to arrive at an understanding between the hospitals and physicians concerned.

8. *Supplemental Report of the Board of Trustees on Medical-Surgical Plan*—The Committee recommends the approval of the report.

Now, Mr. President, I move the adoption of these four sections—numbered 5, 6, 7 and 8.

(The motion was seconded and carried.)

DR. BOWERS: "9. *Supplemental Report of the Board of Trustees on Nominations to the Board of Trustees of Medical-Surgical Plan*—The Committee recommends the approval of the report.

PRESIDENT BUTLER: Regularly moved and seconded that it be approved. Any comments?

DR. HAROLD K. EYNON (Camden): I merely want to ask a question, sir. In your nominations to the Board of Trustees of the Medical-Surgical Plan you have there an employee of the Medical-Surgical Plan. Is that proper procedure or should we have him as an adviser as an employee of that Plan?

PRESIDENT BUTLER: I presume you are referring to Dr. Borsher, is that right?

DR. EYNON: That's correct.

PRESIDENT BUTLER: Well, I'll direct the query to the Chairman of the Reference Committee on their recommendation.

DR. BOWERS: Well, actually we hadn't considered it from that point of view. We see no objection to it, unless there is some legal reason for not appointing him.

DR. SCHAAF: Mr. Chairman, Members of the House of Delegates: I wonder whether the speaker was intending to suggest that there is some impropriety in having a salaried employee of the corporation as a member of the Board. It is common practice in the largest insurance companies, including the Prudential

Insurance Company of America, to have a paid president who is also chairman of the board who participates in all the deliberations of the board. This is standard practice among insurance companies, and I would like to allay the gentleman's anxiety on the subject.

PRESIDENT BUTLER: Thank you. Are there any other comments? If not, are you ready for the question? All those in favor signify by saying "Aye;" contrary, "No," The motion passes and Section 9 of the report is approved. Proceed, Dr. Bowers.

DR. BOWERS: Section 10 refers to the Supplemental Report of the Board of Trustees on the Medical Service Administration. Section 11 refers to the Supplemental Report of our Trustees with respect to nominations for the Board of Governors of Medical Service Administration. We approved both reports.

I move that these two sections of our Reference Committee report be approved.

(This motion was seconded and passed.)

The final section of our Reference Committee's report is as follows:

12. *Resolution on Medical Fees in the Medical-Surgical Plan, submitted by Dr. Edward G. Gullord, Delegate from Essex County* — The Committee agrees with this resolution in principle and recommends that the Board of Trustees of The Medical Society of New Jersey, in conjunction with the Board of Trustees of the Medical-Surgical Plan, take it under advisement.

Mr. President, I move the adoption of the report of the Reference Committee as amended.

PRESIDENT BUTLER: You have heard the motion to adopt the report as a whole, as amended. Any comment? All those in favor signify by saying "Aye;" contrary, "No." So ordered.

Thank you very much, Dr. Bowers.

The next report will be the report of Reference Committee "D." Dr. Charles A. Landshof is the Chairman.

DR. CHARLES A. LANDSHOF (Hudson): Reference Committee "D" had for its consideration the reports of the Medical Defense and Insurance Committee, the Medical Education Committee, the Physicians Placement Service Committee, and the Emergency Medical Service, Civil Defense Committee. The Widows and Orphans of Medical Men Committee informed us that it had no occasion to meet during the year 1955-56 and submitted no report.

1. *Medical Defense and Insurance* — The Reference Committee unanimously approved the report of the Medical Defense and Insurance Committee, including the recommendations that Faulhaber and Heard and E. and W. Blanksteen be continued as official brokers for the Society in their respective fields. The Reference Committee commends this committee and its chairman for the time and effort they have devoted to the interests of our members, particularly in connection with professional liability insurance. The Reference Committee believes, however, that more detailed information should be made available to all the members of the Society so that the problems involved in medical defense insurance would be better understood.

2. *Medical Education* — The Reference Committee unanimously approved the report of the Medical Education Committee. The Reference Committee commends the efforts of this committee to obtain adequate financial support to promote a useful and comprehensive program.

3. *Physicians Placement Service* — The Reference Committee unanimously approved the report of the Physicians Placement Service Committee. The Reference Committee commends this committee on its work during the past year. We suggest that its reports be given wider publicity through state and county publications.

4. *Emergency Medical Service, Civil Defense*— The Reference Committee unanimously approved the report of the Emergency Medical Service, Civil Defense Committee and commends the committee for the time and effort it has devoted to this problem. The Committee recommends, however, that the wording of the resolution presented by this committee be changed as follows:

The first clause of the 6th paragraph which now reads:

"Now therefore be it resolved by the House of Delegates of The Medical Society of New Jersey that there be established a Department of Civil Defense Disaster Control in the Department of Defense of the United States" be changed to read:

"Now therefore be it resolved by the House of Delegates of The Medical Society of New Jersey that this Society recommends the establishment of a Department of Civil Defense Disaster Control in the Department of Defense of the United States."

(This report, on motion, was adopted section by section, and also as a whole.)

PRESIDENT BUTLER: Reference Committee "D's" report has been adopted. Thank you, Dr. Landshof. Now let us hear from Dr. Gannon, speaking for Reference Committee "E."

DR. JOSEPH M. GANNON (Union): Reference Committee "E" examined, and recommends for approval as submitted, the following reports:

Welfare Committee
Cancer Control Committee
Maternal and Infant Welfare Committee
Legislative Committee
Public Relations Committee
Medical Practice Committee
Industrial Health Committee
Workmen's Compensation Committee
Public Health Committee

Conservation of Hearing and Speech Committee
Conservation of Vision Committee
Routine Health Examination Committee
School Health Committee

2. *Resolution re Indigent Patients in Nursing Homes*—This resolution from the Board of Trustees was approved by the Reference Committee:

Whereas, as of January 1, 1956, the State Department of Institutions and Agencies established a policy affecting chronically-ill public assistance patients in licensed proprietary and non-profit nursing homes through New Jersey, and

Whereas, under the terms of that policy a maximum monthly rate of assistance of $168 was set, of which it is estimated a maximum of $6 per month is available for all medical costs including drugs and physicians' fees, and

Whereas, under that policy the proprietors of nursing homes can decide when and how often a doctor should be called, and can—on the basis of budgetary limitations—determine even the nature and extent of treatment, and

Whereas, such a situation is inimical to the best interests of the patient, violates the doctor-patient relations, and encourages control of medical practice by unqualified lay persons.

Therefore be it resolved, that The Medical Society of New Jersey disapprove the inclusion of payment for medical care in the amount assigned to proprietors of nursing homes for the overall monthly care of public assistance patients, and

Be it further resolved, that The Medical Society of New Jersey recommend that the Department of Institutions and Agencies modify this unsatisfactory policy so that the control of and compensation for medical care will be dealt with on an individual basis and as an independent fiscal item.

Your Reference Committee recommends to the House the adoption of this resolution.

3. *Resolution re Old Age Assistance* — A resolution also from the Board of Trustees was approved by the Reference Committee. Here is the text:

Resolved, that The Medical Society of New Jersey be urged to attempt to have the law in New Jersey changed in order to provide for the direct payment of physicians for medical services rendered to recipients of Old Age Assistance as contrasted with the present procedure whereby the Welfare Board pays the recipient who in turn is expected to pay the physician.

The Reference Committee recommends the adoption of this resolution by the House of Delegates.

4. *Resolution re Arthritic Sufferers in New Jersey*—This resolution from an Essex delegate was approved by the Reference Committee:

Whereas, the New Jersey Chapter of the Arthritis and Rheumatism Foundation, 671 Broad Street, Newark 2, New Jersey, is about to engage in a general census of arthritic sufferers throughout New Jersey beginning in the month of June, 1956, and

Whereas, the information thus obtained will be invaluable in developing the program of the New Jersey Chapter of the Arthritis and Rheumatism Foundation for the relief and rehabilitation of arthritic sufferers, be it therefore

Resolved, that The Medical Society of New Jersey approve and endorse in principle the proposed census of arthritic sufferers in our state, and be it further

Resolved, that The Medical Society of New Jersey request its members to cooperate in the conduct of the census whenever possible.

The Reference Committee recommends the adoption of this resolution by the House of Delegates.

5. *Resolution on Salk Vaccine*—The original resolution from the Union County Medical Society was discussed at great length. It was generally agreed the essential intent of the resolution was to make federally purchased vaccine available in physicians' offices. Representatives from Union County were present at the meeting and they concurred with the suggestion of the Committee that the original resolution be modified. The Reference Committee therefore recommends that the original resolution be rejected and the following substitute resolution be adopted:

Whereas, the distribution of federally purchased Salk vaccine in New Jersey has proved inequitable and inadequate; and

Whereas, this circumstance has resulted in great dissatisfaction both to the public and physicians of New Jersey and has generated marked dissension; and

Whereas, the questionable method of distribution of federally purchased Salk vaccine in New Jersey adopted by the State Department of Health has invited wastage of the vaccine; and

Whereas, in full conformity with federal law, numerous other states have seen fit to make the federally purchased vaccine available to physicians for use in their private offices; therefore

Be it resolved, that The Medical Society of New Jersey, in annual meeting assembled, urges that the State Department of Health:

(1) Liberalize its policies of distribution of Salk vaccine; and

(2) In the future distribute all federally purchased Salk vaccine in accordance with the aforementioned ruling of the United States Public Health Service, which permits federally purchased Salk vaccine to be given in physicians' offices with the proviso that no charge may be made for the vaccine itself; and

Be it further resolved, that a copy of this resolution be sent to the Governor of New Jersey and the State Commissioner of Health.

The Report of Reference Committee "E"

was adopted, section by section, and also as a whole, by vote of the House of Delegates.

PRESIDENT BUTLER: Now I call on Dr. Albright to read the report of the Reference Committee on Constitution and By-Laws.

DR. LOUIS F. ALBRIGHT (Monmouth): All members of the Committee were present. Here is our report.

1. *Report of Board of Trustees, 1955 Amendments*—The committee unanimously approved the report of the Board of Trustees, titled "1955 Amendments to Constitution and By-Laws." The committee also wishes to take this opportunity to speak parenthetically in relation to some of the material contained in this report relating to the appointment of a specific Committee on Revision of Constitution and By-Laws in conformity with the provision of Article XII, and Chapter XV. The committee feels that it is the intent of the Constitution that such a Committee on Revision of Constitution and By-Laws should be a standing committee, and that it should function throughout the year. Our committee heartily endorses the action of the Board of Trustees in this respect. Furthermore, we feel that the existence of this committee and its proper functioning will avoid many of the problems which have so stubbornly beset us in our deliberations this year.

DR. NEWBURY: Does that actually introduce an amendment to establish a standing committee?

PRESIDENT BUTLER: My opinion is that it does not. It is merely declaring what they think would be a good policy.

DR. ALBRIGHT: Speaking parenthetically, we underline that. It would appear to our Committee that the Board of Trustees felt that no new motion or amendment was necessary; that the establishment of such a committee was implicit in the Constitution as it now stands. I am not an expert on the Constitution.

PRESIDENT BUTLER: No, but you were asked a question, and I think he has answered what their intent is in what they felt was implied in the By-Laws. Is that right?

DR. ALBRIGHT: That is right, sir.

DR. NEWBURY: If you want to establish a standing committee an amendment should be introduced to the By-Laws to establish another standing committee. I agree there should be a standing committee.

PRESIDENT BUTLER: All right, that's merely your opinion. Are there any other remarks?

DR. NEWBURY: Can't this be introduced as an amendment to the By-Laws since it is introduced at the first session? That will clarify the thing.

PRESIDENT BUTLER: As I understand it, this is not a question of an introduction of a By-Law. It is a question concerning the adoption of the proposed motion by the Reference Committee, and any comments here are directed towards that. This has nothing to do with the introduction of a new By-Law. This is merely their interpretation of what they think is implied in the present setup of the By-Laws.

DR. ALBRIGHT: Remember that we were considering a report from the Board of Trustees, and I said: The Committee unanimously approved the report of the Board of Trustees, titled "1955 Amendments to Constitution and By-Laws'." Reference to this report will make it clear that there is no substance in the report which would establish a committee. It would seem to me that any such move at this time would constitute entirely new business.

DR. HENRY A. DAVIDSON: The By-Laws provide that a non-Delegate may, with permission, have the privilege of the floor. I'm asking for that.

PRESIDENT BUTLER: Dr. Davidson, who is the Editor of THE JOURNAL, wishes the privilege of the floor, I presume, to speak on the motion that is before the House. Do I hear any objection? Dr. Davidson.

DR. DAVIDSON: An inherent absurdity here accounts for this dilemma. The Constitution specifies that all proposals to amend the Constitution or By-Laws be referred to the Committee on Constitution and By-Laws. Obviously a motion to amend the By-Laws by creating such a committee could never go through because it requires that that motion be referred to the committee. It's a non-existent committee; it can't be referred to as a committee. The only possible interpretation is the thesis that if the Constitution itself says that there is a Committee on By-Laws, this gives it constitutional recognition. The only step remaining is for the Trustees to establish such a committee. You can't have an amendment to the Constitution to establish it because the provision is that that amendment must be referred to that committee to be considered. Since the Constitution recognizes it, all you need do is have the Board of Trustees create a Committee on Constitution and By-Laws.

PRESIDENT BUTLER: Thank you, Dr. Davidson.

DR. ALBRIGHT: We have carefully and at length considered this question. The Constitution specifically states that there shall be a Reference Committee on Constitution and By-Laws and that, as we have heard previously today, it shall be appointed immediately following the opening meeting of the House of Delegates.

The Constitution, Article XII, says: "This Constitution may be amended by a two-thirds

vote of the members present at any annual meeting, provided the proposed amendments have been considered by the *Committee on Revision of Constitution and By-Laws,* and that they shall have been submitted in writing at a previous annual meeting, shall have been published in the JOURNAL of this society, and officially sent to each component society at least three months before the annual meeting at which final action is to be taken."

Now, that could not conceivably refer to the Reference Committee on Constitution and By-Laws because such Reference Committee is not in existence at a time which would chronologically fit into this very specifically detailed procedure for the treatment of amendments to the Constitution and By-Laws.

It was inherent in the Constitution as it is now written that there be a standing committee known as the Committee on Revision of Constitution and By-Laws and we felt that the Board of Trustees had recognized this fact and they have established such a committee. We endorse their recognition of this fact and hope that the establishment of this committee will get around many of these things that this year have been stumbling blocks.

PRESIDENT BUTLER: Any other remarks? If not, are you ready to vote on the proposed motion of the Reference Committee for approval? All those in favor signify by saying "Aye;" contrary, "No." So ordered.

DR. ALBRIGHT: May I continue? Here is the next part of our report:

2. *Resolution from Union County, 1955 Amendments*—The committee unanimously rejected and disapproved the resolution, titled "1955 Amendments to the Constitution and By-Laws," as submitted by the Union County Medical Society. The committee does not feel that the Board of Trustees exceeded the Board's constitutional powers when the Board declared invalid the action of the House of Delegates in regard to amendments to the Constitution and By-Laws dealt with at the 1955 Annual Meeting.

On motion made, seconded and carried, the Reference Committee's recommendation in Section 2 (above) was carried. Dr. Albright then continued with:

3. *Amendment to Article VI, Board of Trustees, from Union County*—The committee unanimously rejected the proposed amendment, titled "Article VI—Board of Trustees," proposed by the Union County Medical Society. The committee feels that this proposed amendment may contain much of merit, but it did not feel that it could conscientiously approve this proposed amendment at the present time. The committee feels that this amendment should be the object of careful study and intensive investigation by the Committee on Revision of Constitution and By-Laws during the coming year.

DR. ALBRIGHT: Mr. President, I move the adoption of this portion of the report.

(The motion was seconded.)

PRESIDENT BUTLER: You have heard the motion for the adoption of this portion of the report. Any comments? Dr. Purcell of Mercer.

DR. ERNEST F. PURCELL (Mercer): Mr. Chairman, House of Delegates: Changes in the composition of the Board of Trustees were approved last year by this House of Delegates. Later it was said that a legal error had been committed in that it had not been presented to the then non-existent Committee on Constitution. It had been published; it had gone through all the legal channels except that this non-existent committee had not considered it before our session last year.

Now, this year it has been re-submitted; it has been presented to all committees; it has gone through all legal channels; it has gone to the Committee on Constitution and By-Laws for their perusal before it has come up at this House of Delegates meeting.

Now, because the Reference Committee and the majority of the Delegates approved this change in the Constitution last year, with very little change this year, and because a number of the counties consider that they should have some representation on the Board of Trustees, we would again approve this change because it is a democratic way of representation. It will provide a direct liaison between every county society with the State Society. The representatives can report directly to their own county society and get immediate cooperation for any matters that the State Society needs to have presented at the local level. And the final action, when we sum it all up, depends on the action of the House of Delegates.

So I ask you to approve the resolution as presented by the Union County Delegates so that each individual county should have representation on the Board of Trustees. This will increase the number of the Board of Trustees by eight. It would not make it an unwieldy group. They can still do their business, but you as individual county members can get information from your representative which will be in your hands so much quicker than if you had to wait until the next Society meeting. So therefore, gentlemen, I would ask you to consider the approval of the Union County resolution on these grounds. Thank you. (Applause)

DR. MORICONI: Mr. President, House of Delegates; I thought that possibly you people ought to hear what the Mercer County Medical Society thought about this thing and why we were for it, the purpose of it. We are not per-

sonally interested. We have a very fine member of the Board of Trustees from Mercer County; we don't intend to change him. But the idea is to make a little more democracy work. Every member should know what goes on in our Society. I don't know of a better way of finding out what goes on all year long than having somebody representing every county so that whatever business is being transacted will get back to them directly.

This can't cause any harm. It's nice to have everybody know what's going on all the time before it happens. We have a precedent. There were some remarks about the fact that probably this would not be a representative group; it doesn't represent the population directly. That's true. But neither does, for instance, the Nominating Committee of 21 from 21 counties. Each member of the Nominating Committee is a Nominating delegate named from each county. That's 21 nominating delegates with the Past-President acting as the Chairman. That's not a representative group either.

Essex County has 90 delegates and one nominating delegate. Salem County has three delegates with one nominating delegate, so that the equivalent is there. No harm is done by that. We agree that's a good way of getting a cross-section of every county. We are not in disagreement with it at all. Another precedent is set.

There is not direct representation here. There are at least four counties, probably six counties that don't deserve to have three delegates because they don't have that many members of their own county societies to represent that. I could name at least four that I am sure of, possibly six. Nobody objects to those three delegates coming here and wielding their power and informing us on things or voting for or against things. We are in favor of those men being here because we want them to be representatives of their county.

We feel exactly the same way about the Board of Trustees. We are not asking for a disproportionate representation. We feel that this would act as a sort of a guiding body and with a good way of getting things back to everybody before the year is up. Actually a great many of the men who come here don't know a thing about what's going on at the State level.

We in Mercer County are very fortunate because outside of some confidential stuff, any time we run short of something, we want to know what's going on at the Board of Trustees we ask our man. I think the same privilege should be offered to every county society within the State.

DR. ALBRIGHT: I would like to speak on behalf of the action of the Committee. We tried to choose our words carefully. We said: "The Committee unanimously rejected the proposed amendment." We avoided reference to "disapprove." We felt strongly the obligation conferred upon us in the approval for adoption of any motion which we felt might be far reaching in its consequences. Dr. Moriconi's reference earlier in this meeting to the advance presentation of the material to be covered to the chairman is an excellent suggestion. It is very difficult properly to digest the material in the few hours allotted and in the usual course of proceeding.

In many respects, as the gentlemen said, this is a democratic way of doing things. I just want to bring to your attention a few of the things that were brought out at the meeting of our Committee and say that we felt that possibly a better method of achieving this desirable result might be the calling of a constitutional convention or some modification; so that this material might be better subjected to greater and more intensive study certainly than we had the opportunity to do. Now a 21-man Board would, in some respects, be a cumbersome group. For 190 years the Society has done well and we were loath hurriedly to change the procedure. We feared, too, that conceivably there might develop splinter groups in this larger Board of Trustees: that you might get groups dedicated to geographical consideration. There would, to be sure, be some inequality in respect to representation of the doctor population. We felt also that there were obvious fallacies in considering the Board of Trustees to be the upper house of the legislative body of the State Medical Society. Obviously we do not have two houses. The Board of Trustees is an interim, I might say, administrator rather than an upper house. A comparison to other types of governmental legislative bodies is inappropriate.

And we also felt—this possibly might not turn out to be true, but it is notorious that the incidence of absenteeism in larger groups of elected delegates is high.

PRESIDENT BUTLER: Thank you, Dr. Albright.

DR. EMANUEL M. SATULSKY (Union): If you reject the adoption of Section 3 of this report of the Committee on Constitution and By-Laws, what does it mean? (1) It gives you, the Delegates to this Society, the opportunity to decide whether you wish the Board of Trustees to be composed of one representative from each component county society elected by each county society. (2) It reaffirms the action which you took last year, in which you went on record as approving the selection of one repre-

sentative from each county society to serve on the Board of Trustees.

Your vote today is *not* a final vote. This will come up for final vote next year. If this is referred to committee for study, next year at this meeting we will have a chance to vote on it finally.

A DELEGATE: Only one question for clarification. To vote for the Union County amendment we must vote "No" on this proposal, is that correct?

PRESIDENT BUTLER: You are correct. If you vote "Yes," you will sustain the action of the Reference Committee in disapproving the amendment as introduced by Union County. Is that clear? Are you ready for the question? All those in favor of the motion of approval of the recommendation as proposed by the Reference Committee will signify by saying "Aye;" contrary, "No." The motion is disapproved.

DR. MORICONI: Mr. Chairman, I move the adoption of the Union County amendment.

(The motion was seconded.)

PRESIDENT BUTLER: Regularly moved and seconded that the Union County amendment be adopted. Are there any remarks?

DR. NEWBURY: As the motion now stands, the election of the Board of Trustees by each component county society will have to take place thirty days after the adoption of the amendment. Through discussion it was felt that this is a rather short period of time and we would like to amend that to read sixty days. The question, remember, is on Section 2, about the fourth line: "Thereafter, at the expiration of those terms each Trustee shall be elected for three years. ***Members of the present Board of Trustees shall hold office until their successors are elected." That, I believe, is in the supplemental report already.

PRESIDENT BUTLER: You are voting on the original report and whatever that contains is what the House is voting on, whether it is 30, 60, 90 or 100 days. That is what you are voting on.

All those in favor of Dr. Moriconi's motion for adoption of the Union County amendment will signify by saying "Aye;" contrary, "No." The "Ayes" have it.

DR. ALBRIGHT: That, then, would change the status of Number 4 which was actually a twin.

.4 *Amendment to Article VI, Board of Trustees, from Mercer County*—The committee unanimously disapproved the proposed amendment, titled "Article VI—Board of Trustees," as proposed by the Mercer County Medical Society which, in essence, was very similar to the amendment discussed immediately prior to this one. Again we feel that this resolution also contains much material that warrants further consideration and which may prove meritorious. Again we would suggest that these amendments be carefully studied in the coming year.

DR. MORICONI: Point of order! Must we vote this one down in order to make the other one effective? Otherwise, we are voting one against the other.

DR. ALBRIGHT: If we vote this one down, then there is no conflict of interest.

PRESIDENT BUTLER: Right. But you must go through the motions of voting on their recommendation approving or disapproving of it. This is a motion to approve the Reference Committee's report on the amendment to Article VI from Mercer County, in which they disapprove Mercer County's action, and that has been seconded.

DR. ALBRIGHT: There were two amendments submitted to us; one from Union County and one from Mercer County, very similar; there were just a few differences in phrasing. You have adopted the one from Union County. Now, if you should adopt the one from Mercer County you would have a conflict. So that the Reference Committee has recommended the rejection of the Mercer County amendment to Article VI.

PRESIDENT BUTLER: Dr. Albright has no alternative other than to bring in the report of his Reference Committee, which disapproved that amendment. That is what you are voting on; their disapproval of that amendment. I think it is perfectly clear. If you want to disapprove it you must do it on this motion.

All those in favor signify by saying "Aye;" contrary, "No." It has been disapproved. Now I think you want to make another motion.

DR. ALBRIGHT: I would like to try to get them straightened out on this. There were two very similar amendments: one from Union County and one from Mercer County. The Reference Committee recommended the disapproval of each of these; however, in the case of the Union County amendment which preceded the Mercer County amendment our recommendation was not accepted and then the Union County amendment was voted on favorably.

Now, as I said in our report which you have in your hands and which I cannot change at this late date anyway, it contains our original disapproval of the Mercer County amendment. Now, this amendment is virtually the same as the one you have approved. But if you approve the Mercer County, too, then you would have difficulty in resolving minor differences between the two, which is only going to make a lot of red tape. And I would

suggest that this vote be taken again. Maybe if you will accept our recommendation that the Mercer County amendment be disapproved, then you set the Union County amendment up in the clear as you have done in the previous motion.

DR. MORICONI: Mr. President, I want to withdraw the Mercer County amendment.

(Applause)

DR. ROCCO M. NITTOLI (Union): Mr. Chairman, if there is very little difference between the Union County and the Mercer County, and Mercer County is willing to accept the Union one, I think we have erred in voting the way we did. Therefore, being one of those who have erred, I move for a reconsideration of the vote so that we can again vote in the proper manner and degree.

DR. MORICONI: I did not bring up the Mercer County amendment for action. We simply voted down the recommendation of the Reference Committee in that paragraph 4 which has to do with the Mercer County amendment on the basis of the fact that we adopted the Union County amendment, which is exactly the same as ours. We are withdrawing our amendment so that we make the Union County amendment effective so there won't be any contradiction.

DR. NITTOLI: That cannot be done in that way, Mr. Chairman.

PRESIDENT BUTLER: I have been informed that you cannot withdraw an amendment which has been proposed by your county, Dr. Moriconi.

DR. BRODKIN: While Dr. Moriconi speaks very well for Mercer County, he is not the Mercer County Medical Society and he by himself cannot withdraw amendments already passed by that Society.

Now, Dr. Moriconi is guilty of falling over his feet on this thing on the previous vote. We have adopted or we have passed in this convention disapproving the recommendation of the Committee, thus approving actually the Union County amendment. Now, all we have to do—very simple—is to approve the Committee's report disapproving the Mercer County amendment.

DR. HERSCHEL S. MURPHY (Union): May we hear from the Parliamentarian how he would solve this? That is what he is here for.

DR. JAMES S. SHIPMAN (Camden): I don't think it matters whether we vote yes or no. We will uphold Mercer County if we vote no. The Committee's report is disapproval, which means Mercer County only has to say nothing, and they've got everything accomplished. All we need to do is vote no on the Committee's report.

PRESIDENT BUTLER: That has already been done. May I have the Parliamentarian explain to the Delegates his opinion on the proposition?

THE PARLIAMENTARIAN: There are probably several ways of straightening this out. Of course, in the first place, I want to tell you that I am not supposed to be a legal authority on the effect of all these things. I came here to make technical parliamentary rules, and what the ultimate effect of this and that is I don't think that that is a question for a Parliamentarian. It's a question for your legal counsel.

If you are anxious to sustain your previous action in disposing of Number 3—in the first place, I can't understand why two things that were almost identical were here. However, in Number 3 you have rejected the report of the Reference Committee and then right after that you have affirmatively adopted this amendment which was proposed by Union County, and you wish to be consistent.

Now, when you came to Number 4, you have disapproved the report of the Reference Committee. You could stop right there because no further action has been taken by your body with reference to the original amendment of Mercer County. Until some one makes an affirmative motion that it be adopted, it hasn't been done. So if you don't do it, it dies.

That is one way of handling it. It is the simplest way and shortest way. If you want to be technical about it, if you want to reconsider your action in disapproving Number 4, you can go all through that red tape.

My suggestion is that you leave it die. As far as I am concerned, the original amendment of Mercer County is dead for failure to take any affirmative action one way or the other on it.

PRESIDENT BUTLER: Does that satisfy everybody? (Applause)

Will you proceed then, Dr. Albright?

DR. ALBRIGHT: Here is item 5 in our Reference Committee report:

5. *Amendment to Article XII—Amendments, from Union County*—The committee unanimously disapproved and rejected the proposed amendment, titled "Article XII—Amendment to the Constitution and By-Laws," proposed by the Union County Medical Society. The committee felt that the Constitution traditionally should be a formalized declaration of inherent simplicity and that it should not be encumbered with the multiplicity of mechanisms with which the proposed amendment is overburdened. Again, traditionally, the Constitution should spell out fundamentals, and amendments to it should be more formalized than amendments to its By-Laws. Furthermore, its context could not be rationalized with the present statement of the

Board of Trustees with which your committee was concerned in its initial deliberations of the afternoon, and which action was approved here in Item 1. This report of the Board of Trustees had to do with the method of procedure by which amendments to the Constitution and By-Laws should be received. Inherent in this method of treatment of amendments to the Constitution and By-Laws was their submission to the Committee on Revision of Constitution and By-Laws. As previously stated, this concept could not be reconciled with the context of this proposed amendment.

DR. NEWBURY: We in Union County spent a lot of time studying this. We felt that, in many respects the Constitution is not clear. For instance, there is controversy over the way amendments should be developed, particularly last year when the action of the House of Delegates was thrown out by the Board of Trustees. Now, we feel that some attempt should be made to clarify the articles in both the Constitution and the By-Laws.

The Constitution and By-Laws are not some sacred document that can't be changed. I don't believe there have been changes in many, many years. There are, as we said before at the first meeting, three references to Committees on Constitution and By-Laws. They are all different, and the same controversies might come up many times.

We offered this as a suggestion which, of course, you can take or reject. Now, this is again only at first reading. This doesn't mean that if you vote to consider this, that it is going to be passed finally. It can still be rejected next year, but we would like you to consider it. After all, you will have a standing committee on Constitution and By-Laws. They can consider it again. You will have a whole year to go over this. We hope it might stimulate some interest among the other county societies in order that these By-Laws could be clarified to some extent. That's why we have introduced all these amendments.

PRESIDENT BUTLER: Any other comment? If not, are you ready for the question? All those in favor signify by saying "Aye;" opposed, "No." It's carried. Please continue, Dr. Albright.

DR. ALBRIGHT: Here is item 6 of our report:

6. *Amendments to Chapter V—Selection of Officers, from Union County*—The committee unanimously disapproved and rejected the proposed amendment, titled "Chapter V—Selection of Officers," proposed by the Union County Medical Society. It was felt that the proposed legislation contained a great many objectionable features in the mechanism by which it was proposed that the officers be elected. Among these objectionable features was the distinct possibility that multiple nominations might result in the sidetracking of desirable and strong candidates and the election of compromise candidates, to the detriment of The Medical Society of New Jersey. Another very objectionable feature of the proposed legislation was the provision that there could be no nominations from the floor at the annual meetings.

On motion made and seconded, this recommendation was adopted.

DR. ALBRIGHT: Here is item 7:

7. *Amendments to Chapter VI—Duties of Officers, from Mercer and Union Counties*—The committee unanimously rejected the identically similar proposed amendments, titled "Chapter VI—Duties of Officers," proposed by the Mercer County Medical Society and the Union County Medical Society. This proposed legislation had to do with change in quorum of the Board of Trustees, had the legislation increasing the number of trustees been acted upon favorably. Since such was not done, these twin proposals are purposeless.

DR. ALBRIGHT: We would have to feel now that a change in the quorum of the Trustees would be corollary to a change in the size of the Board. The House wishes to increase this from 18 to 24. The present quorum is 9. If you follow the general rule that a quorum is a majority, you would probably want a quorum of 14. I need parliamentary advice as to whether I can change the Committee recommendation at this point. The original recommendation was based on the assumption that the size of the Board would remain at 18.

THE PARLIAMENTARIAN: May I ask you a question? Do I understand in view of what has happened already it would be inconsistent to have the recommendations of your Reference Committee adopted? Is that right?

DR. ALBRIGHT: It would be inconsistent. You could poll the Committee here, if you care to. It is inconsistent.

THE PARLIAMENTARIAN: You are duty bound to report this as you were instructed by your Reference Committee. However, the House of Delegates may vote this down and then there may be an affirmative motion made to reinstate what your Committee rejected.

MR. NEVIN: May I have the privilege of the floor?

PRESIDENT BUTLER: Mr. Nevin, Executive Officer, wishes the privilege of the floor.

MR. NEVIN: Gentlemen of the House of Delegates: Amendments to the Constitution take two years to be formally adopted. Amendments to the By-Laws are adoptable at the given session. If you adopt an amendment to the By-Laws, the effect of which is to establish the quorum of the Board at 14, then next year when we are continuing with the Board whose total membership is 18, it would be re-

quired that all through next year 14 be the quorum of that Board. It seems to me, therefore, that in the event that this House ultimately decides by constitutional amendment that the Board is to consist of the officers and a representative from each county, then that would be effective two years from now. You are voting now on the By-Laws which goes along as a concomitant of that to take place not at this convention but next year.

PRESIDENT BUTLER: I would assume that under those circumstances the proper thing to do in the present situation would be to sustain the action of the Reference Committee and it would eliminate all of that difficulty, and then a similar proposal can be made next year.

DR. MORICONI: I think we should simply reject the recommendation of the Committee and let it die, just like we let the other one die.

PRESIDENT BUTLER: What will you do about a quorum?

DR. MORICONI: Next year we will bring it up. The quorum stays the same because it won't be effective until next year. We just reject that; we're done.

PRESIDENT BUTLER: That's the proper way to handle it.

DR. COMANDO: If we want to accomplish what has been brought out, all we have to do is sustain the action of the Reference Committee and approve their report rejecting this thing as it relates to quorum. If you reject the report of the Reference Committee, you may find yourself with a quorum of 14.

PRESIDENT BUTLER: Are there any other comments? All those in favor of the recommendation of the Reference Committee on amendments to Chapter VI, Duties of Officers, from Mercer and Union Counties, rejecting it, will signify by saying "Aye;" contrary, "No." It is lost.

There is no affirmative action, so no harm has been done.

Proceed, will you please, Doctor?

DR. ALBRIGHT: Here is Number 8.

8. *Amendment to Chapter VII—Judicial Council, from the Judicial Council*—The committee unanimously approved the amendment, titled "Chapter VII—Judicial Council," proposed by the Judicial Council of The Medical Society of New Jersey, but the committee submits the following added amendment to this proposed legislation: We propose with the consent of the House to insert at the end of the first sentence of Section 5 of Chapter VII the following: "The physician concerned will have the right to appear in his own behalf and may have the advice of counsel." This merely specifies a right already inherent in the mechanism.

Mr. President, I move the adoption of this committee amendment to the proposed legislation, titled "Chapter VII—Judicial Council, Sec. 5."

DR. MURPHY: Mr. President, Members of the House of Delegates: A good many of you were here some four or five years ago when we first talked about this particular problem of the Judicial Council, and I'd like to talk with you just a moment about what this particular part of this means.

Those of you who have your proceedings of your Annual Report on Page 271, at the bottom of the page will find the paragraph headed Number 6. I will read it with you. It says that the Judicial Council may "make and promulgate from time to time such rules and regulations as in its opinion may be necessary to insure the proper functioning of the Judicial Council and the various County Judicial Committees with reference both to the substance and procedure of hearings had by the Judicial Council and such County Judicial Committees. Upon receipt of such rules and regulations by the various County Judicial Committees, the members of said committees shall be bound thereby."

Now, gentlemen, let's analyze this just a minute. After all, in the final analysis the House of Delegates does speak for us. We may have interim groups such as the Board of Trustees talk for us, but in the end analysis we make the decisions.

Now, it seems to me too bad that a group of men sit and advocate some of the privileges about our rights. Why should we give a group of five men the right to make rules which will come back and 21 county judicial committees have to abide by them, without the House of Delegates having anything to say about it? I think we ought to add something there.

I'd like to read to you how I think it should be worded. "To make and promulgate from time to time such rules and regulations as in its opinion may be necessary" and so on, going down next to the last sentence—"both to the substance and procedure of hearings had by the Judicial Council and such County Judicial Committees'; *provided, they* — meaning the rules and regulations—*have been previously approved by the House of Delegates at a regular meeting.* Upon receipt of such rules and regulations by the various County Judicial Committees, the members of the committees shall be bound thereby."

After the House of Delegates has agreed, no county would object to going along with the component group as a whole. But we would all object to having five men, good as they may be, without any hearing by the House of Dele-

gates or without any approval, tell 21 county Judicial Committees that they must accept their ruling on what is to be done and the procedures to be done. They would do the best they could. But after all, actions of any component group should be passed on by the House of Delegates, and to Dr. Moriconi I would say certainly there is no reason why the House of Delegates should not have some chance to be considered.

So I would ask you to consider this motion or amendment or any way you wish to put it in order to have it legal, provided the rules and regulations, standards and proceedings have been previously approved by the House of Delegates at a regular meeting. I so submit it to you as a motion for your approval.

PRESIDENT BUTLER: Well, in effect you are making a substitute motion, is that right?

DR. MURPHY: The Reference Committee has added something. Now we want to add one more thing, that such rules must be passed by the House of Delegates before they become binding on the counties.

(The motion was seconded.)

DR. ALBRIGHT: Of course, I think we were originally talking about our amendment to this proposed amendment, but it is getting late, so I presume that we could deviate a little from that. We considered many of these things concerning the whole proposed amendment as submitted by the Judicial Council. Actually what the Judicial Council does is certainly spelled out pretty much by just this very proposal that is either going to be approved or rejected today, which concerns the method and the ground rules under which the Judicial Council will operate. It's all in this proposed amendment.

There is also, possibly the fact that in our own Constitution it states that there shall be a specific separation of the Judicial and the Legislative branches of our medical society and if there is any point of appeal beyond the State Judicial Council it is to the A.M.A. Judicial Council.

The House of Delegates should and will, by whatever you do today in reference to this particular motion, approve the ground rules under which your Judicial Council operates. Our Committee feels that this proposed legislation coming from the Judicial Council contained no loopholes for any uninhibited actions by a group some years from now.

And once again I would recommend that it be considered as is with this amendment that I proposed about the individual being given the right to appear.

PRESIDENT BUTLER: What I understand, Dr. Albright, is that in your proposal here you are asking for the consent of the House to insert what you quote: "The physician concerned will have the right to appear in his own behalf and may have the advice of counsel." That must first receive the consent of the House in order to be inserted there.

Now, is there any objection to the House having that proposal by the Reference Committee inserted?

DR. MURPHY: I so move.

PRESIDENT BUTLER: In other words, you move for its adoption, its insertion. Is there a second to it?

(The motion was seconded.)

PRESIDENT BUTLER: Regularly moved and seconded that the insertion as proposed by the Reference Committee be permitted by the House of Delegates. All those in favor signify by saying "Aye;" contrary, "No." The "Ayes" have it. So ordered.

Now you go to the question of adoption or rejection of your entire recommendation.

DR. MURPHY: Mr. President, I would now like to submit my proposal to the amendment as a whole that they propose, so it now may be considered before we vote.

PRESIDENT BUTLER: In other words, I presume what you are now saying is that you, as an individual, wish to have the consent of the House for the addition of something else, the same as the Reference Committee asked for consent of the House.

DR. MURPHY: I would like to have the approval of the House on it. I've submitted it as an amendment.

PRESIDENT BUTLER: I believe that it changed substantively the recommendation.

DR. MURPHY: No, it merely spelled it out.

PRESIDENT BUTLER: Will you give it to us again, please, so there will be no question? If it doesn't change the substance of it, I think it would be permissible; but if it does, then I think that it would not be.

DR. MURPHY: Gentlemen, I don't think we object to it as far as it goes. It doesn't change the substance; it just says what we must do before it becomes effective. If the House of Delegates, in the final analysis, shall pass on things, and I think we all agree to that, it merely spells it out and all we have to do is submit this amendment. If you approve of it, then we work on it as a whole and we accept it as a whole and submit it to you for your consideration to be added to this particular recommendation by the Reference Committee; and if you vote on it as a whole and agree to it, I see no objection to carrying on as it is, and the provisions of the decision of the House of Delegates will have final authority to pass on rules, which we all agree is a good thing.

President Butler: I ask Dr. Murphy to spell out the proposed wording that he expects the House of Delegates to approve, and at what point it should be inserted.

Dr. Murphy: Paragraph 6 on Page 271 of your *Transactions* which you were given, your Annual Report: "To make and promulgate from time to time such rules and regulations as in its opinion may be necessary to insure the proper functioning of the Judicial Council and the various County Judicial Committees with reference both to the substance and procedure of hearings had by the Judicial Council and such County Judicial Committees." Here we add: *Provided, such rules and regulations have been approved previously by the House of Delegates at a regular meeting.* "Upon receipt of such rules and regulations by the various County Judicial Committees, the members of said committees shall be bound thereby."

President Butler: He is now asking for consent of the House for the insertion into the Judicial Council's report the specific language which he stated here, which requires approval by the House of Delegates. Is it seconded?

(The motion was seconded.)

President Butler: Are there any remarks? Dr. Featherston, who is Chairman of the Judical Council.

Dr. Daniel F. Featherston (Monmouth): Mr. President, Members of the House of Delegates: This body directed your Judicial Council to set this up, and we have done it. I'm afraid if we follow Dr. Murphy's thinking now you will give us a mandate which will be completely in contradiction to what you have already given us, plus the fact that we will be operating for a year without any rules and regulations for the mechanism of the procedures of the County Judicial Committees because if these rules and regulations for their procedures have to be submitted to the House of Delegates, of necessity it cannot be done until next year, so that we would be a year without the rules and regulations.

There is no conflict in the mechanism. I do not think that Dr. Murphy's proposal is necessary.

President Butler: New business can be introduced at this session only by unanimous consent. If there is any objection to it, it cannot be added. It has to be unanimous consent. There is an objection which has been stated by Dr. Featherston. The resolution to insert it is, therefore, out of order and I so rule.

Now, let's get back to Number 8; dispose of Number 8, will you, please?

Dr. Albright: "The Committee unanimously approved the proposed amendment, titled 'Chapter VII—Judicial Council', as amended." That was the amendment having to do with the individual having the right to appear and to have counsel.

Mr. President, I move the adoption of this portion of the report.

President Butler: Regularly moved and seconded. Any comments?

Dr. Henry J. Mineur (Union): Mr. Chairman, as I understand it, if we approve this now there will be no provision for any supervision of the Judicial Council's activities. On the other hand, immediately following is an almost identical proposed amendment proposed by the Union County Society from which most of the amendment currently under discussion has been taken; but this next amendent, if we were to approve that, would include the specific provisions that we have been discussing.

President Butler: Let's come to that when we do. Thank you for the information, Doctor, but I think we ought to take up this one and vote on the recommendation of the Committee. They unanimously approved the proposed amendment. All those in favor signify by saying "Aye;" contrary, "No." The Ayes have it. So ordered. Now, Dr. Albright.

Dr. Albright: Here is another "Judicial Council" proposal. This one from Union:

9. *Amendment to Chapter VII — Judicial Council, from Union County* — The committee then rejected the proposed amendment, "Chapter VII — Judicial Council," proposed by the Union County Medical Society. This proposed legislation contained much material that was virtually identical with that of the immediately previous legislation, and consequently much of its context was therefore repetitious. As a matter of fact, the amendment suggested by our committee was taken from the legislation proposed by the Union County Medical Society, and we wish to credit them with its origination.

Our previous approval was given preferentially to the amendment proposed by the Judicial Council rather than to that proposed by the Union County Medical Society. We feel that the legislation proposed by the Judicial Council better accomplishes the separation of the Legislative and Judicial branches of the Society as called for under our present Constitution, and more unequivocally establishes the Judicial Council as the supreme judicial body of the Society.

We feel that the proposed amendment of the Union County Medical Society was well conceived but in view of our previous action, we must recommend its rejection.

DR. BRODKIN: Before we leave the subject of the Judicial Council, I'd like to call your attention to the fact that we have —

PRESIDENT BUTLER: Has it any relation directly to what we are voting on, the rejection or adoption of this?

DR. BRODKIN: Yes. I want to call your attention to the fact that we have county committees for disputed medical bills and that this procedure of ruling on these things will be given to the Judicial Council. Now, will you instruct or have some method of procedure adopted where these two functions will be reconciled in the coming year?

DR. BUTLER: You are asking for something that requires some debate.

DR. BRODKIN: I want to call your attention to the fact that one duty is now delegated to the Judicial Council which is now taken up by county—

PRESIDENT BUTLER: I think that under a motion to the Delegates would have to be changed that way.

DR. MURPHY: Apparently we lost out on the other because it required unanimous consent to introduce new business at the last meeting of the House of Delegates. One vote was enough to keep us from considering it. Now we now have the Union County amendment which can be considered and can discuss it.

I'm on the Judicial Committee of Union County and I don't think I'm talking through my hat when I tell you that we are interested in this. We now have workable arrangements. Dr. Featherston and his group do have rules they are working under because we adopted them when we first set up the Judicial Committee several years ago. We do have them for the different counties, so nobody is working out rules and regulations. And, of course, we are in a bad position here because even though you approve Union County you just approved the Judicial Committee, so in order to be consistent you almost have to turn us down. Yet I think that the House of Delegates ought to have the final say about rules. Otherwise five men are going to tell us in Union County, for example, to scrap the rules we now have and throw them out, and the other 21 counties, and we will have to do it if you vote as you have done already.

I ask the Parliamentarian if there is any way I can bring this in in connection with Article 9 which concerns the Judicial Council. It's a little bit confusing and yet I would like to see if we can do something under this one we are voting on now, merely to add that any rules would be approved by the House of Delegates.

THE PARLIAMENTARIAN: Dr. Murphy, I can't tell you the ultimate effect of the adoption or rejection of this. All I can tell you is the ground rule for either adopting it or rejecting it. If you want to add anything of substance to this, it would require unanimous consent. So what you have said is legitimate debate against this proposal of the Reference Committe. That is all I can tell you, and everyone else, every other member of the House of Delegates is entitled to debate it fully and maybe in that manner you might work out what the ultimate effect will be. But I'm in no position to construe what the ultimate effect will be, Doctor.

DR. MURPHY: Mr. President, may I ask Dr. Featherston, who was the one objector before, if we may consider it at this point, to have the House of Delegates pass on the rules?

DR. FEATHERSTONS No, sir. I would object again.

PRESIDENT BUTLER: Thank you.

DR. NEWBURY: We have gone to great lengths to study this Constitution and the various proposals that have been submitted, particularly this one on the Judicial Council. We have a very good working Judicial Council in Union County, which is running smoothly and which is very effective. There are several points in the legislation submitted by the Judicial Council that haven't been pointed out. You have just approved legislation to give the Judicial Council the power to write the judicial code in every one of your counties. You have to be bound by it. That's what that amendment states; that you've got to be bound by whatever rules they write. You have no recourse anywhere.

Now, this provision which you have just passed, if you will look in your procedures under the last paragraph, it's identical almost with the last paragraph under the Judicial Code. If you read those two, with the exception that the one you just passed states that whatever rules are promulgated by the Judicial Council must be binding on the county societies. Now, they already have the power to make rules and they have had it ever since these articles were first approved by the House of Delegates. It's the last paragraph under the Judicial Code. They already have the rules and they are working under the rules. The rules they want now are the rules of an absolute dictatorship to write the rules of your Judicial Code in each county.

Now we already have them; they are working and these men can re-write these rules and if this is sustained I don't know what the Parliamentarian is going to rule or what the council is going to rule later if you pass our

amendment, but I do know that if it is sustained they will have the absolute right to write your Judicial Code.

Now, if you want them to do that, that's all right; that gives five men powers that nobody else in The Medical Society of New Jersey has. As I read over their amendment, there is absolutely no provision in that amendment that they must report back to the County Judicial Committees. When an appeal goes to them or when there is a hearing, you get no report. A reporting requirement was in the old By-Laws. It should be retained, and it is retained under the By-Laws that were submitted by Union County.

We have had experience with this. An appeal was made to the Judicial Council. We sent them all our reports. To this day we don't know what disposition was made of that case. And I am Secretary of the Judicial Committee of Union County.

There must be some provision for reports back from the Judicial Council. You can't set those men up as Star Chamber operators. It simply can't be done if you want to go on any kind of well run working arrangement. That is the second factor that has been omitted in their amendment.

The third factor, which was added last year is this. Their amendment gives them the right to hold hearings and to subpoena any member from The Medical Society of New Jersey. The committees that are being let go the Divisional Judicial Committees also had that power. But the County Judicial Committees, which are going to be the original trial body, do not have the power to subpoena a member from an adjoining county. It will often be impossible to hold hearings or to arrive at any definite conclusion unless you have the power to bring members from other counties. That is also included in the provisions of the Union County amendment. I urge you to reject the recommendation of the Reference Committee on this point and adopt the proposal of the Union County Medical Society.

DR. NATHAN S. DEUTSCH (Union): I want three sentences. First, just to back up Dr. Newbury on Star Chamber procedures. In the set-up now formulated, a small group of men become the judge, jury and prosecutor. Thank God we have done a little amending, so a member can have the right of counsel. That's the first thing.

The second thing is this: we are substantially changing our Constitution, but not by amendment. Our Society is a federation of component medical societies with the supreme body being the House of Delegates. The only way according to our Constitution that a man can be expelled is either through the House of Delegates or through his component society. We are waiving all of these rights. We are letting one group of men now tell each county something which your State Society can't do itself. Any decision that you make in the State Society is not binding on the various component societies, but they may or may not do as you ask. You recommend. We are giving to a small group the power to tell us what to recommend. (Applause)

DR. JOHN F. KUSTRUP (Mercer): I have just one sentence. Should it not be the duty of this Judicial Council only to interpret these rules and not to make them?

DR. FEATHERSTON: These rules that you are talking about are merely rules of procedure. They are not rules that tell you what to do or will affect the decision of your Judicial Committees in any way. We are only trying to get the counties in the State doing things in the same manner as to reporting. Union County is very wrong if they said they weren't told about what the decision of the Judicial Council was in their case. Only trying to set procedural rules as to the form of complaints, how they shall be submitted, when they shall be heard, and where the reports go. That is all this rule and regulation business is about. (Applause)

DR. ALBRIGHT: I would emphasize everything Dr. Featherston has said. In your Committee's deliberations on this subject, we carefully considered these two measures. We gave preferential consideration to that Judicial Council's proposal. We agree that there is something to be said for some standardization of procedure at the county level. After all, you want the same kind of justice in one end of the state as you get in the other. Actually these are merely the ground rules under which the Judicial Committees or Councils operate.

As far as the over-all approval of the House of Delegates, whatever rules are promulgated by the Judicial Council when they reach the county level the county at that time has the prerogative of again bringing up any change here that they desire to make. Actually, as I said today, we had the opportunity in the consideration of previous legislation to approve these ground rules, and I would certainly urge that you support your Committee on Constitution and By-Laws in the action that they took in the consideration of these two.

DR. KENNETH L. DAY: Under Section 3, Paragraph 6 it specifically states that the Judicial Council is to "make and promulgate from time to time such rules and regulations as in its opinion may be necessary to insure the proper functioning of the Judicial Council

and the various County Judicial Committees with reference both to the substance and procedure of hearings ***." It also mentions the substance of the hearings, not just the procedure.

DR. MURPHY: I'd like to ask Dr. Albright a question. He says if the Council isn't satisfied they may ask for consideration. Ask whom?

DR. ALBRIGHT: Bring it right back as an amendment.

DR. MURPHY: To whom? You have just given the right to the Judicial Committee and they have made the ruling. Are you going to ask them to rule on their own action?

DR. ALBRIGHT: No. These rules of procedure are subject to the approval of the House of Delegates.

DR. MURPHY: It doesn't say so. It says they may make their own.

DR. ALBRIGHT: Why have we spent all this time going over revisions? I mean you can curb anything you have given them.

DR. MURPHY: It doesn't say so. It says they are binding. I ask Dr. Albright if the County Judicial Committee isn't satisfied and they wish to make a request, to whom do they relay that request. You said the State Judicial Council.

DR. ALBRIGHT: I think implicit in this arrangement is that the State Judicial Council isn't going to ram anything down anyone's throat.

DR. MURPHY: That has nothing to do with my question, sir.

DR. ALBRIGHT: No, but there would be consultation at least between the State Judicial Council and the County Judicial Committee, at that level. Now, we'll say if you still are aggrieved, some time elapses, I'll have to grant you that; but you could once again bring before this body a proposal to amend the Constiution and By-Laws in respect to the powers of the Judicial Committee or Judicial Council, just the same as we'll say analogous type of legislation we are considering today.

DR. MURPHY: Mr. President—

PRESIDENT BUTLER: I would consider that's an answer to the question. Has anybody else—

DR. MURPHY: May I ask you a question, sir? Does that mean if we give them the power today, later on we may ask for it back?

PRESIDENT BUTLER: I don't see why not.

Anybody else care to comment? If not, are you ready for the question?

DR. ALBRIGHT: Mr. President, I move the adoption of this portion of the report.

PRESIDENT BUTLER: That concerns the amendment to Chapter VII, the amendment from Union County. Do I hear a second?

(The motion was seconded.)

PRESIDENT BUTLER: The motion is to reject. All those in favor of the Committee's recommendation will signify by saying "Aye;" contrary, "No." The Ayes have it. The amendment is rejected.

DR. ALBRIGHT: Here comes item 10 in our Reference Committee report. You will hear reference now to Paragraph G. Let me explain. Paragraph G lays down a time-table for the Reference Committee, and under some conditions they could not possibly get the deliberations finished, the reports written, edited, reproduced and distributed within the tight schedule decreed in G. That's why we would like to omit G. Here is our report:

10. *Amendment to Chapter VIII—Committees, from Union County*—The committee approved the proposed amendment, titled "Chapter VIII—Committees," proposed by the Union County Medical Society, with the deletion of paragraph G under Section 14 (this should properly be Section 13, as pointed out in the Supplemental Report of the Board of Trustees). The committee deleted paragraph G because of the obvious hardship it might easily impose upon a reference committee. At times the stipulations of paragraph G would be virtually impossible of accomplishment. This legislation as amended spells out procedure under which reference committees would operate. The committee feels that this is desirable even though most, if not all, is contained in Robert's Rules of Order, under which we operate.

Mr. President, I move the adoption of this portion of the report. You might ask the Parliamentarian if the deletion of a paragraph constitutes an amendment.

PRESIDENT BUTLER: The answer, I believe, is that at times it does, but in the particular case it it merely a matter of form and not substance and therefore does not change substantially the intent. Do I hear a second?

(The motion was seconded and passed.)

DR. ALBRIGHT: Before I read recommendation 11, let me explain that the previous proposal, which was rejected would have set up a new procedure to handle amendments to the Constitution and By-Laws. If that had passed, then you could delete from the Constitution and By-Laws the present paragraph. Since this proposal was rejected, I think it is obvious that we must retain what is in our Constitution and By-Laws.

11. *Amendment to Chapter XV—Amendments, from Union County*—The committee was obliged

to reject the proposed amendment, titled "Chapter XV—Amendments," proposed by the Union County Medical Society since its previous disapproval of the proposed amendment, titled "Article XII — Amendment to the Constitution and By-Laws," makes it incumbent upon us to retain "Chapter XV—Amendments."

PRESIDENT BUTLER: Regularly moved and seconded that this portion of the report be adopted. Any comments? All those in favor signify by saying "Aye;" contrary, "No." So ordered. The "Ayes" have it. So ordered. Now, Dr. Albright.

DR. ALBRIGHT: Here are the two final recommendations. Let me read them together:

12. *Amendment to Chapter V—Selection of Officers, from the Board of Trustees*—The committee unanimously approved the proposed amendment, titled "Chapter V—Selection of Officers," submitted in the supplemental report of the Board of Trustees.

13. *Report of the Board of Trustees, 1956 Proposed Amendments*—The committee unanimously approved the Supplemental Report of the Board of Trustees, titled "1956 Proposed Amendments to Constitution and By-Laws."

DR. ALBRIGHT: I move the adoption of the Reference Committee's report as a whole as amended.

(Seconded and passed).

And now, let me take this opportunity to point out the tremendous amount of work that Mrs. Madden and her staff do. Last night these girls worked until 2:30 a.m. getting these reports printed. To my amazement they still seem to be as fresh as ever. I don't think many of us realize how hard they work. (Applause)

PRESIDENT BUTLER: After all the Reference Committees had reported I was going to thank them, but I am sure you will agree with me that Dr. Albright and his Committee deserve a special vote of thanks. That was a monumental task. (Applause)

PRESIDENT BUTLER: Before I go on, there is one matter that was by-passed before. Dr. Forte, may we hear a report from the Committee on Credentials?

DR. FORTE: Mr. President, there are 306 Delegates.

PRESIDENT BUTLER: Thank you! And now for another Reference Committee. Dr. Diskan will report for his Reference Committee on Miscellaneous Business.

DR. SAMUEL M. DISKAN (Atlantic): Here is our report:

1. *Advisory Committee to the Woman's Auxiliary*—The Committee accepts the Woman's Auxiliary Advisory Committee report with thanks and expreses its appreciation. We note the valuable assistance rendered our Society by our Woman's Auxiliary, and recommend that they be so notified.

2. *Annual Meeting Committee*—The entire report of the Annual Meeting Committee and its recommendations are approved. We commend the early beginning of the Delegates' meeting which clears all conflicts with the remainder of the convention program, and we urge its continuance.

3. *Scientific Exhibit Committee*—The Committee accepts the report of the Scientific Exhibit Committee, and we commend the selection of exhibits and the efficiency of performance of this committee.

4. *Scientific Program Committee*—We accept the report of the Scientific Program Committee and express our thanks and gratitude for the excellent performance of a difficult job well done.

Mr. President, I move the adoption of this report.

(This motion was seconded and carried.)

PRESIDENT BUTLER: And now for our final Reference Committee. Speaking for the Reference Committee on Resolutions and Memorials, is its chairman, Dr. Buchanan.

DR. RALPH M. L. BUCHANAN (Warren): Our report comes in two paragraphs, one concerning honorary members, and one on emeritus members. There were no nominations for honorary membership, and we ask your approval of the committee's report to that effect.

(On motion made, seconded and carried, this part of the report was approved.)

Nominations for emeritus membership were received from 8 counties. We endorse them all and recommend that these emeritus memberships be conferred. Here is our list:

Atlantic County—Benjamin L. Gordon, M.D.

Bergen County—J. Bennett Edwards, M.D.; George W. Finke, M.D.; Abraham B. Spiegelglass, M.D.; Joseph S. Van Dyke, M.D.

Camden County—Earl S. Hallinger, M.D.; Max Ruttenberg, M.D.; Joseph D. Seiberling, M.D.

Essex County—Anne Jane S. Brim, M.D.; Donald M. Caldwell, M.D.

Hudson County—Roland J. Lynch, M.D.

Mercer County—Nathaniel H. Koplin, M.D.; George N. J. Sommer, Sr., M.D.

Passaic County—Samuel Ginsburg, M.D.; Louis Lipton, M.D.; Harold G. Walker, M.D.

Somerset County—Edgar T. Flint, M.D.; Mason W. H. Pitman, M.D.

DR. BUCHANAN: The Reference Committee recommends the adoption of this portion of the report. Mr. President, I so move.

DR. L. SAMUEL SICA: Mr. President, I second the motion, but I now ask for a suspension

of the rules so that we may give special consideration to the name of Dr. Sommer.

PRESIDENT BUTLER: You have heard the request from Dr. Sica that the rules be suspended so that he may give consideration to the honorary membership of Dr. George Sommer. There are no objections. Proceed, Doctor.

DR. SICA: I move the following resolution:

Whereas, Dr. George N. J. Sommer of Trenton has since 1896 been a member in good standing of The Medical Society of New Jersey, and

Whereas, his years of membership have been years of distinguished service, during which he advanced to Presidency of The Medical Society of New Jersey, and

Whereas, by his attainments as a surgeon and his services as a citizen he has well deserved the gratefulness of both his colleagues and his fellowmen, and

Whereas, now, in his 82nd year, he has been admitted to the status of emeritus membership in The Medical Society of New Jersey; therefore be it

Resolved, that The Medical Society of New Jersey, through its House of Delegates, hereby acknowledge its profound indebtedness to and deep affection for Dr. Sommer for the example and profit of his life to medicine and to mankind.

PRESIDENT BUTLER: Regularly moved and seconded. All those in favor signify by saying "Aye;" contrary, "No." Adopted by acclamation!

Thank you very much.

You have heard the motion, and it has been seconded, for the nominations for emeritus membership. This is the recommendation of your Reference Committee.

PRESIDENT BUTLER: Regularly moved and seconded. Are there any comments? All those in favor signify by saying "Aye;" contrary, "No." So ordered.

DR. BUCHANAN: Mr. President, I move the adoption of this report of the Reference Committee as a whole.

(The motion was seconded.)

PRESIDENT BUTLER: Any comments? All those in favor signify by saying "Aye;" contrary, "No." So ordered.

Thank you very much, Dr. Buchanan. And I thank every other member and the Chairmen of all of these Reference Committee. They have done a tremendous job, and it behooves everybody to recognize that, as I am sure they do.

Is there any unfinished business?

PRESIDENT BUTLER: At this time it is my distinct pleasure to introduce to the House the gentleman whom the House of Delegates chose for their Second Vice-President for this coming year. I'm sure he is very well known to all of you; he is and has been to me personally for a good many years, and I am sure that the Society will be better for him. I'd like to have him come up and be introduced to the House. Our new Second Vice-President, Dr. Clyde Bowers. This is our new Second Vice-President. Welcome to our midst.

(Applause)

The President of Somerset County has a presentation to make to our incoming president.

DR. JOHN L. SPALDO: Mr. President, Delegates, and Members of our Society. I take this opportunity, as the President of the Somerset County Medical Society, in behalf of our members, to present to our President, Dr. Lewis C. Fritts, a gift unique and I hope inspiring. It is a gavel, hand-carved, an inspiration of a fellow member, Dr. Emerson Bird. It is made of wood grown in New Jersey. I would like to read the inscription. "This gavel was made from white oak tree located in Bound Brook, New Jersey, on the property of E. F. Bird, M.D. According to tradition, the first land title in Somerset County secured from the Indians was consummated under this tree."

So, Lewis, long may you bang it with authority and dignity. (Applause)

DR. FRITTS: Thank you very much.

PRESIDENT BUTLER: Thank you very much, Dr. Spaldo.

At this time I ask Dr. Henry Decker, a Past-President of The Medical Society of New Jersey, to come up to present to the Delegates our Incoming President.

DR. HENRY B. DECKER: Mr. President, Members of the House of Delegates of The Medical Society of New Jersey: New Jersey has an interesting history in its settlement. It was settled by the Dutch primarily who traveled up valleys—the Hackensack, the Passaic, the Raritan and in the Delaware Valley above the Water Gap, the Minisink Flats.

The Dutch settlers were an interesting people. They had solved their problems in Holland; they had solved their religious difficulties; they had solved their political difficulties. They had set up a republic, and the Pact of Utrecht was the forerunner of our Declaration of Independence.

They went up the Raritan Valley and there they met another group of people coming down the valley, the Palatinate Germans, who had left Germany to find freedom in a new coun-

try that William Penn had set up. The Germans went to Easton, crossed into New Jersey and came down the valley, so that in Hunterdon and Somerset Counties we find a peculiar mixture of these people of the same racial origin—people who had in ancient times successfully fought the Roman Empire and kept them within proper bounds. These people mingled in Hunterdon and Somerset Counties for the benefit of those counties and New Jersey.

Spruce Run is an area in Hunterdon County, a very delightful area. One of these individuals settled in Spruce Run, had a farm there, then a large family in Colonial times. They stayed there pretty much until after the Civil War.

When the railroads came into prominence, the farm boys felt that railroading was an adventure. Many of them left. One of them was the father of the gentleman who is your President. In his occupation on the railroad he moved into the Town of Hoboken where this young man was born. Hoboken is an Indian name — Hoboken-Pati, meaning the place where one smokes.

He left Hoboken at the age of seven months and either walked or was carried to the Oranges. Later he left the Oranges and went to Scranton where he grew up. He went to the Technical High School in Scranton and from there to Pennsylvania State College, presently the Pennsylvania State University, where he successfully completed his undergraduate studies, probably with some distinction because he was accepted for admission to a medical school. While at Pennsylvania State College, he joined the Delta Upsilon fraternity and was the champion heavyweight boxer.

In 1926 he came to the Jefferson Medical College in Philadelphia and there he successfully completed his studies and he belonged to the Nu Sigma Nu Medical Fraternity.

From his medical school days—and that is where I first met him in 1926 so I have known him for almost half a lifetime—he went to the Philadelphia General Hospital as an intern. Finishing that, he went to Dr. Crile's clinic in Cleveland as a surgical Fellow. Completing his training in surgery, he came back to Somerville to practice. Somerville is a part of my New Jersey. I have kinfolk there, so I saw him quite frequently.

Of course, he was successful in practice in Somerville and as a surgeon on the staff of Somerset Hospital. But he also met a very delightful and attractive girl in Somerville and they were married and presently they have three children: Ann, Cornelia and Jimmy, who are also delightful children.

While in Somerville he attained the respect of the community. This I know because I have kinfolk who live there, although I live in another part of New Jersey south of the Rancocas. He is Warden of his church. He has attained the respect and regard of his fellow-practitioners. This gavel, which was to be presented after I had introduced him, is a token of that.

Why he asked me to introduce him, I don't know, because there are so many things that I could tell. I am complimented by it, though, because every teacher is always proud when a student is successful. They feel that they have achieved some small portion of immortality; that something of them which they hope is good has rubbed off on this individual. He may have invited me because we have been friends for half a lifetime.

Now, I know this man very well. I know that he will never use his office for the advancement of any personal gain, nor will he permit any man to speak against another physician for any personal gain. He is a man, a gentleman, and a physician.

I give you the President of our Medical Society of New Jersey, Lewis Fritts.

DR. LEWIS C. FRITTS: Thank you, Dr. Decker, for you kind introduction of me.

I want to thank my colleagues from Somerset County for this beautiful gavel and block. I'm going to use it now.

Is there any more business to come before this House of Delegates? If not, I will entertain a motion for adjournment.

(Upon motion, the meeting was then adjourned *sine die*, at 1:02 p.m.)

REPORTS, RESOLUTIONS AND AMENDMENTS

TREASURER'S REPORT

Jesse McCall, M.D., Newton
(Reference Committee "B")

BALANCE SHEET — MAY 10, 1956

GENERAL FUND

ASSETS

Cash	$213,460.89
Accounts Receivable	2,016.40
Inventory Maternal Welfare Record Books—at cost (contra)	580.50
Investments—U.S. Savings Bonds	27,500.00
Land, Buildings, and Equipment (contra)	106,885.46
Total	$350,443.25

LIABILITIES AND SURPLUS

A.M.A. Dues Payable	275.00
Assessments Collected Applicable to 1956-57	92,662.50
House Committee Reserve	766.98
Annual Meeting Reserve	14,554.65
A.M.A. Dues Collection Reserve	481.99
Membership Directory Reserve	9,928.06
Medical Journal Reserve	7,163.36
Lands, Buildings, and Equipment (contra)	106,885.46
Maternal Welfare Record Books Reserve (contra)	580.50
Surplus	117,144.74
Total	$350,443.25

PERMANENT CAPITAL FUND

Cash	$ 3,565.25
Investments	11,500.00
Total	$ 15,065.25

STATEMENT OF RECEIPTS AND DISBURSEMENTS FOR FISCAL YEAR
1955-56 — June 1, 1955 - May 10, 1956

RECEIPTS

Cash on Hand, June 1, 1955 $202,353.97

Assessments:	A.M.A.	State	Total
Atlantic County	$ 3,825.00	$ 4,680.00	$ 8,505.00
Bergen County	12,487.50	16,672.50	29,160.00
Burlington County	2,100.00	2,490.00	4,590.00
Camden County	7,200.00	9,090.00	16,290.00
Cape May County	775.00	990.00	1,765.00
Cumberland County	1,850.00	2,460.00	4,310.00
Essex County	30,450.00	39,497.50	69,947.50
Gloucester County	1,625.00	2,040.00	3,665.00
Hudson County	12,125.00	15,510.00	27,635.00
Hunterdon County	1,000.00	1,260.00	2,260.00
Mercer County	8,787.50	10,555.50	19,343.00
Middlesex County	6,100.00	7,732.50	13,832.50
Monmouth County	5,400.00	7,800.00	13,200.00
Morris County	5,200.00	6,300.00	11,500.00
Ocean County	1,200.00	1,470.00	2,670.00
Passaic County	10,500.00	15,525.00	26,025.00
Salem County	1,150.00	1,380.00	2,530.00
Somerset County	2,050.00	2,610.00	4,660.00
Sussex County	900.00	1,170.00	2,070.00
Union County	12,800.00	15,540.00	28,340.00
Warren County	800.00	1,020.00	1,820.00
Total	$128,325.00	$165,793.00	$294,118.00

A.M.A. Dues Refunds	237.50	
1955 Membership Directory	3,002.75	
Journal Advertising (net)	39,783.91	
Technical Exhibits	12,135.00	
Interest	1,322.40	
Sale of Maternal Welfare Books	1,008.00	
Rents	740.00	
Payroll Taxes	358.68	
Janitorial Services	85.00	
A.M.A. Dues Collection	1,482.76	
Sale of Land	2,500.00	
Miscellaneous	798.69	
Prior Year State Assessments	225.00	
Total Receipts		357,797.69
TOTAL		$560,151.66

DISBURSEMENTS

BUDGET ACCOUNTS		
A- 1—Executive Salaries	$ 45,366.24	
A- 2—Executive Office Salaries	23,828.50	
A- 3—Executive Office Expenses	2,215.76	
A- 4—Executive Travel	1,915.93	
A- 5—House Maintenance	8,803.04	
A- 6—Treasurer	1,928.19	
A- 7—Finance and Budget Committee	67.40	
A- 9—Audit	600.00	
A-10—Secretary	1,853.92	
A-11—Salary Taxes	1,427.44	
A-12—Insurance	1,271.90	
B- 1—Journal Publication	5,000.00	
B- 5—Journal Office Expenses	403.49	
B- 6—Journal Travel	—	
C- 2—Welfare Committee	702.82	
C- 3—Legislative Committee	3,411.22	
C- 4—Public Health Committee	1,013.84	
C- 5—Public Relations Committee	4,499.71	
C- 6—Medical Practice Committee	507.10	
D- 1—President and Other Officers	2,849.16	
D- 2—A. M. A. Delegates	4,500.58	
D- 8—Woman's Auxiliary	6,212.71	
D-13—Medical Education Committee	38.99	
D-20—Medical-Dental Liaison Committee	41.19	
D-21—Medical-Hospital Liaison Committee	38.99	
D-22—Medical-Legal Liaison Committee	38.99	
D-23—Membership, Directory, Physicians Placement	12,507.88	
D-24—Medical Research Committee	—	
D-26—Medical-Pharmaceutical Liaison Committee	38.99	
D-27—Emergency Medical Service, Civil Defense Committee	64.55	
D-28—Medical-Nursing Liaison Committee	38.99	
D-29—American Medical Education Foundation	25,000.00	
E- 1—Board of Trustees	846.04	
E- 2—Contingent	8,488.62	
E- 4—Judicial Council	349.07	
F —Legal	—	
TOTAL BUDGET ACCOUNTS		$165,871.25
Accounts Payable, May 31, 1955		2,759.03
Annual Meeting		4,007.71
Journal Publication		29,730.86
Commissions		6,841.73
Janitorial Service		70.00
A. M. A. Dues		129,637.50
A. M. A. Dues Collection Expenses		1,582.76
Assessments Refunded		187.50
House Committee Reserve Expenses		6,002.43
Total Disbursements		$346,690.77
Cash Balance, May 10, 1956		213,460.89
TOTAL		560,151.66

For action, see page 16.

SUPPLEMENTAL REPORT

BOARD OF TRUSTEES

C. Byron Blaisdell, M.D., Chairman, Asbury Park

Subsequent to the presentation of the annual report of the Board of Trustees published in the May JOURNAL, the items listed below were considered at meetings of the Board and are referred to the House of Delegates for consideration.

STUDENT LOAN FUND

(Reference Committee "B")

At the 1955 Annual Meeting a resolution was received from the Woman's Auxiliary through the advisory committee to the Auxiliary requesting the consideration of the "establishment of the student loan fund to assist the individual New Jersey student in meeting expenses incidental to his training in medical school." The resolution was tabled by the committee for further study.

A special committee was appointed by the Board of Trustees in October, 1955 to study the proposal. The following recommendations were made by the special committee and have been approved by the Board of Trustees.

1. That such a fund be established, and that it be called the Medical Student Loan Fund of The Medical Society of New Jersey.

2. That it be administered by a special committee of not more than five members of The Medical Society of New Jersey, of which committee it is suggested, the President and the Executive Officer be *ex-officio* members.

3. The fund be available to medical students who have satisfactorily completed the first two years of study in an approved medical school of the United States or Canada, and who have been *bona fide* residents of New Jersey for not less than five years prior to matriculation in medical school. Under exceptional circumstances, consideration may also be given to deserving first or second year students.

4. To qualify, the student, as well as fulfilling the requirements outlined above, must be of good moral character, of acceptable academic standing, and must be able to prove financial need.

5. The maximum amount to be annually available to any borrower should be $1,000, to be repaid in the same amounts in which the loan was made, with repayment to begin two years after the establishment of practice. Interest of 3 per cent will apply on the unpaid balance from the date of the borrower's entrance into practice.

6. Each loan is to be secured by a note, and term life insurance, naming The Medical Society of New Jersey as beneficiary, will be required of each borrower in an amount to cover his total indebtedness to the fund. In the event the student fails to sustain regular premium payments, such payments shall be assumed by The Medical Society of New Jersey and their cost added to the total of the student's debt.

7. In any one year the committee shall not disburse monies in excess of 20 per cent of the total fund on hand.

8. Applications for loans should be addressed to the chairman of the special committee.

As regards the creation of the fund it is suggested:

a. That funds up to $3,000 be taken temporarily from surplus for the first year; and

b. That voluntary contributions be encouraged as donations to the general fund or as specific memorial grants.

For action, see page 17.

MEDICAL-SURGICAL PLAN

(Reference Committee "C")

Regarding the 1955 resolution of the House of Delegates on x-ray therapy for cancer, the Board received a report that the entire x-ray problem has been discussed at length, but in view of communications and conferences with the radiologists, no action was taken on the resolution by M.S.P.

"Principles of Approach on Specialty Services Such as Radiology, Pathology, Anesthesia, Electro-Cardiograms, etc." were approved by the Board and sent to the New Jersey Hospital Association inviting its attention to the principles and urging that steps be taken to develop the proposals, suggesting a joint conference. Initial conference was held on March 4, and it is expected that others will follow.

Approval was given to a change in the new series 1956 subscription contract:

a. That the $5,000 limitation be continued with respect to single person contracts: and

b. That the income limitation with respect to all other contracts be $7,500, but include the joint income of subscriber and spouse, if any.

The Board's action was in conformity with the 1955 action of the House of Delegates which approved the supplemental report of M.S.P. — among other things, that supplemental report provided that payment to a participating physician for services under the new contract would constitute payment in full unless the annual income of either the subscriber or of the spouse, if any, was more than $5,000. In effect, this gave approval to a combined income of up to $9,999 as acceptable.

Authorization was given by the Board to M.S.P. to make the apportionment of available benefits depend upon the procedure, to include other services such as pre- and postoper-

ative care and be not limited to surgical assistance within the range of $10 to $50. This is in conformity with A.M.A. policy and equitable in accordance with the increased fees under the new 1956 contract to which the range will apply.

For action, see page 19.

NOMINATIONS TO BOARD OF TRUSTEES OF MEDICAL-SURGICAL PLAN OF NEW JERSEY

(Reference Committee "C")

The Board of Trustees of The Medical Society of New Jersey recommends the following nominations for membership on the Board of Trustees of Medical-Surgical Plan of New Jersey:

Charles W. Barkhorn, M.D.
Irving P. Borsher, M.D.
Harry N. Comando, M.D.
Patrick H. Corrigan, M.D.
William F. Costello, M.D.
Joseph P. Donnelly, M.D.
Joseph I. Echikson, M.D.
Joseph M. Keating, M.D.
Arthur W. Lunn
Paul Mecray, Jr., M.D.
Royal A. Schaaf, M.D.
Rudolph C. Schretzmann, M.D.
Edward W. Sprague, M.D.
John S. Thompson
Thomas J. White, M.D.
Carl K. Withers

For action, see page 19.

MEDICAL SERVICE ADMINISTRATION

(Reference Committee "C")

At the request of the Board of Governors of Medical Service Administration, approval was given for the expansion of M.S.A. facilities so as to permit payment to be made through M.S.A. for services of dentists, chiropodists, opticians, and optometrists in cases approved by the Essex County Welfare Board. There will be no supervision of or responsibility for these services by M.S.A.; it will merely serve as the agency through which bills are paid for services approved by the Welfare Board.

In connection with this, M.S.A. requested a statment from the Trustees as to handling of disputed bills. The following action was taken by the Board in response to the request:

It is proper for M.S.A. to review and approve bills for payment for other agencies; any disputes which may arise will be referred for adjustment to a liaison committee of the professional societies concerned, in the counties involved.

The Board authorized a contribution of $5,000 to M.S.A. to cover operating expenses for 1956 with the amount charged against the budget allotment indicated for such contribution.

For action, see page 20.

NOMINATIONS TO BOARD OF GOVERNORS OF MEDICAL SERVICE ADMINISTRATION OF NEW JERSEY

(Reference Committee "C")

The Board of Trustees of The Medical Society of New Jersey recommends the following nominations for membership on the Board of Governors of Medical Service Administration of New Jersey:

Harry N. Comando, M.D.
William F. Costello, M.D.
Arthur W. Lunn
Royal A. Schaaf, M.D.
Rudolph C. Schretzmann, M.D.
Edward W. Sprague, M.D.
John S. Thompson
Thomas J. White, M.D.

For action, see page 20.

OLD AGE ASSISTANCE

(Reference Committee "E")

The following resolution from the Monmouth County Medical Society was approved by the Board of Trustees and is referred to the House of Delegates:

Resolved, that The Medical Society of New Jersey be urged to attempt to have the law in New Jersey changed to provide for the direct payment of physicians for medical services rendered to recipients of Old Age assistance as contrasted with the present procedure whereby the Welfare Board pays the recipient who in turn is expected to pay the physician.

For action, see page 21.

1956 PROPOSED AMENDMENTS TO CONSTITUTION AND BY-LAWS

(Reference Committee on Constitution and By-Laws)

In accordance with the provisions of Article XII and Chapter XV of the Constitution and By-Laws, a Special Committee on the Revision of Constitution and By-Laws was appointed by the Board of Trustees to review

proposed amendments and determine if they were in proper form.

The following report of the special committee was received and approved by the Board of Trustees:

1. *Article XII—Amendments*

The following observations supplied by counsel are endorsed as regards the proposed amendment to Article XII submitted by the Union County Medical Society:

a. Constitution is historically the supreme law of any organization, and amendments to it should be more formalistic than amendments to its by-laws.

b. Would permit of amendments to constitution within a period of four months — hardly ample to discuss the pros and cons of a change in the organic law.

c. Section 12 would permit of "sleeper" amendments to both Constitution and By-Laws.

d. For reasons already stated here, it could not be adopted this year.

2. *Chapter V, Selection of Officers*

The following observations supplied by counsel are endorsed with regard to the proposed amendment to Chapter V as submitted by the Union County Medical Society:

This amendment

In Section 1, (a), eliminates representative of the Fellows.

In Section 2, (b), changes meeting date from 8:30 p.m. on first day of annual meeting to some date between ninety and sixty days prior to annual meeting. Chapter V is made rather complex.

In Section 3, (d), prohibits nominations from floor except where there is no nominee.

3. *Chapter VII, Judicial Council*

A. The special committee suggested a few minor changes to the proposed amendment to Chapter VII as submitted by the Judicial Council. These changes were accepted by the Council and have been made in the amendments submitted for the consideration of the House.

B. The following observations of counsel on the proposed amendment to Chapter VII, as submitted by the Union County Medical Society, are endorsed:

Section 7, subdivisions (8) and (9) — "embody novel proposition which in effect seeks control of the actions of the appellate tribunal by the trial court. Subdivision (4) of Section 7, which gives the Judicial Council power to establish procedure on appeal, would be emasculated. The Judicial Council has the right to establish rules permitting determination of appeal on record, or by trial *de novo*, without let or hindrance from trial court."

4. *Chapter VI, Section 5, Board of Trustees*

The proposed amendments to Chapter VI, Section 5, from the Union County Medical Society and the Mercer County Medical Society, were reviewed without comment.

5. *Chapter VIII, Section 14, Reference Committees*

The proposed amendment to Chapter VIII, Section 14, from the Union County Medical Society, was reviewed without comment except that the correct Section number is "13."

6. *Chapter XV, Amendments*

The proposed amendment to Chapter XV, from the Union County Medical Society, was reviewed without comment.

7. *Article VI, Board of Trustees*

The following comment is made with regard to the proposed amendments to Article VI submitted by the Mercer County Medical Society and the Union County Medical Society:

Should this amendment be adopted in its present form, it will become effective as of the time of its formal adoption. The result would be to disestablish the old Board of Trustees as of that date, but to make no provision for the establishment of the new Board for a period of some nine or ten months or until the new Board members have been elected at the next succeeding annual meeting of each component county society.

The respective county societies were notified by the Board of the defect in their proposed amendments so that they could modify their proposals if they so desired. The following modification was received from the Union County Medical Society:

Section 2. Provided that within thirty days following the adoption of these amendments the first seven (7) counties alphabetically, from Atlantic through Essex, shall elect for one (1) year, the second seven (7) counties from Gloucester through Morris, for two (2) years, and the third seven counties, from Ocean through Warren, shall elect for three years. Thereafter, at the expiration of those terms each Trustee shall be elected for three (3) years. After two (2) years Article VI, Section 2 shall be automatically deleted from the Constitution without further amendment. Members of the present Board of Trustees shall hold office until their successors are elected.

The following modification was received from the Mercer County Medical Society as an addition to the final paragraph of the original proposed amendment:

The newly-elected Board of Trustees will take office at the Annual Meeting of the House of Delegates immediately succeeding the one at which this amendment is adopted.

The above modifications are referred to the House of Delegates without comment.

For action, see page 34.

INDIGENT PATIENTS IN NURSING HOMES
(Reference Committee "E")

A letter from the Atlantic County Medical Society and a resolution from the Union County Medical Society condemned the new policy of the State Department of Institutions and Agencies in the matter of medical management for indigent patients in nursing homes in New Jersey.

The Board of Trustees approved the following resolution and submits it to the House of Delegates for consideration:

Whereas, as of January 1, 1956, the State Department of Institutions and Agencies established a policy affecting chronically-ill public assistance patients in licensed proprietary and non-profit nursing homes through New Jersey, and

Whereas, under the terms of that policy a maximum monthly rate of assistance of $168 was set, of which it is estimated a maximum of $6 per month is available for all medical costs including drugs and physicians' fees, and

Whereas, under that policy the proprietors of nursing homes can decide when and how often a doctor should be called, and can—on the basis of budgetary limitations—determine even the nature and extent of treatment, and

Whereas, such a situation is inimical to the best interests of the patient, violates the doctor-patient relations, and encourages control of medical practice by unqualified lay persons.

Therefore be it resolved, that The Medical Society of New Jersey disapprove the inclusion of payment for medical care in the amount assigned to proprietors of nursing homes for the overall monthly care of public assistance patients, and

Be it further resolved, that The Medical Society of New Jersey recommend that the Department of Institutions and Agencies modify this unsatisfactory policy so that the control of and compensation for medical care will be dealt with on an individual basis and as an independent fiscal item.

For action, see page 21.

MEDICAL TESTIMONY IN MALPRACTICE CASES
(Reference Committee "A")

During the year a joint committee of the Medical Society and the New Jersey State Bar Association has endeavored to arrive at a solution to the problem of attorneys obtaining medical testimony in malpractice cases.

The following resolution is submitted for the consideration of the House of Delegates. By agreement, an identical resolution is being considered by the New Jersey State Bar Association at its meeting today.

Whereas, both the New Jersey State Bar Association and The Medical Society of New Jersey have for some time been concerned with the difficulty of obtaining expert medical testimony in actions alleging malpractice, and

Whereas, that difficulty is aggravated by the disinclination of doctors to testify in cases in which no clear distinction is made between negligence and bad result, or in cases of doubtful merit; therefore

Be it resolved, that the New Jersey State Bar Association and The Medical Society of New Jersey hereby recommend that a joint committee be established by the New Jersey State Bar Association and The Medical Society of New Jersey, to be available to determine the merits of alleged malpractice cases submitted to it, on a voluntary basis for evaluation.

For action, see page 15.

CONSTITUTION AND BY-LAWS
AMENDMENT
(Reference Committee on Constitution and By-Laws)

The Board of Trustees recommends approval of the addition of the following paragraph to the By-Laws:

Chapter V—Selection of Officers

Section 6—Beginning of Term of Office

c. In the absence of a Delegate, any Alternate Delegate who is available shall be eligible to serve.

For action, see page 34.

AMERICAN MEDICAL EDUCATION FOUNDATAION
(Reference Committee "B")

The Board of Trustees recommends to the House of Delegates that The Medical Society of New Jersey make a donation to the American Medical Education Foundation and that the necessary additional assessment to cover such donation be included in the dues.

For action, see page 16.

SUPPLEMENTAL REPORT

MEDICAL DEFENSE AND INSURANCE

(Reference Committee "D")

J. Wallace Hurff, M.D., Chairman, Newark

During the past year your committee has been deeply conscious of a definite lack of appreciation by physicians of the gravity of our present situation relative to professional liability protection and its cost. This applies to individuals as well as groups, in spite of the earnest effort of the committee to report the situation as it sees it. The study below is a break-down of statistical data, relative to claims. It answers some of the questions relating to this problem.

STUDY NO. 1

Year	Claims	Year	Claims
1946	60	1951	87
1947	55	1952	105
1948	85	1953	101
1949	101	1954	96
1950	93	1955	122

In reviewing the above study, from an experience standpoint, no worthwhile conclusion can be drawn unless this problem is considered over a period of years—112 per cent increase in the number of claims reported over a ten-year period, with a 30 per cent increase in the past year. Premium rates are based on experience, and your committee cannot fail to express its deep concern over a 30 per cent increase in claims in one year.

A dollar graph shows a much greater rise—approximately 350 per cent increase in losses paid and reserves maintained on outstanding claims since 1947. This emphasizes that we are not only confronted with a marked increase in the *number* of cases reported, but a still greater percentage of rise in the *cost* of claims.

From a premium standpoint it is certainly evident that the increase in rate was warranted, and if the present trend should continue we possibly will be faced with further adjustments.

Study No. 2 below presents this picture on a county basis. There are outstanding changes evident that are worthy of consideration. We call to your attention that:

From March 1, 1955—March 1, 1956
- 15 counties reported claims
- 6 counties, no claims reported
- 12 counties reported increase in number of claims
- 2 counties reported decrease in number of claims
- 1 county, no change
- 125 claims reported for this one-year period

During the past ten years
- All counties reported 1 or more claims
- 908 claims reported in past ten-year period

STUDY NO. 2—TEN YEAR RECORD OF CLAIMS

	1946	1947	1948	1949	1950	1951	1952	1953	1954	1955	Ten Yrs.
Atlantic	1	4	—	1	3	—	1	1	3	4	18
Bergen	7	2	4	6	4	4	13	10	12	10	72
Burlington	—	—	—	—	—	—	—	—	—	2	2
Camden	1	4	2	1	1	2	1	—	4	8	24
Cape May	—	—	—	—	—	—	—	—	—	1	1
Cumberland	—	—	2	—	2	1	2	—	1	—	8
Essex	13	14	24	27	28	29	31	28	21	24	239
Gloucester	—	—	2	—	—	1	2	—	—	—	5
Hudson	11	7	7	20	12	15	19	11	13	21	136
Hunterdon	—	1	—	—	—	—	2	1	—	—	4
Mercer	3	—	3	3	7	6	2	3	7	11	45
Middlesex	2	2	7	4	6	4	8	9	2	8	52
Monmouth	3	2	6	11	6	3	5	7	5	7	55
Morris	—	3	1	2	2	2	1	3	1	4	19
Ocean	1	—	2	3	—	1	1	2	4	—	14
Passaic	10	5	11	12	16	12	8	12	13	12	111
Salem	—	—	—	—	2	3	—	—	—	1	6
Somerset	—	—	1	—	—	—	4	5	1	—	11
Sussex	—	1	—	1	2	—	—	—	—	—	4
Union	7	9	12	10	2	6	5	9	7	11	78
Warren	—	1	—	—	—	—	—	1	1	1	4
	59	55	84	101	93	89	105	102	95	125	908

We present this data with the hope that each county society will study and interest itself to the extent of endeavoring to make every effort to reduce the claim experience in its county.

Particularly, we would call attention to the fact that on a ten-year basis, we now have claims for one out of 4½ doctors. This year one doctor in 32 has experienced a claim—the highest on record.

Study No. 3 is a one-year review, inaugurated last year, with the hope that our members will appreciate the fact that loss from medical liability insurance is not confined to any one group, but is fairly well distributed through the practice of medicine.

STUDY NO. 3

TYPE OF CLAIMS REPORTED —

March 1, 1955 to March 1, 1956

Obstetrics and Gynecology	14
Surgery	21
X-ray	4
Orthopedics	7
Eye, Nose & Throat	11
Anesthesia	9
Physiotherapy	1
Genitourinary	3
Neuropsychiatry	5
General Practice	
Patients injured, result of falls	8
Needles and injections	13
Penicillin	1
Improper or incomplete diagnosis	6
Miscellaneous	15
Unclassified	7

In reviewing the above breakdown your committee had no difficulty in evaluating the total claim loss in the respective groups. We know from observations that losses from a group standpoint vary from year to year. For example, a small group of highly specialized physicians might show a low claim record one year, whereas the following year the group may have several losses which could wipe out the premium income for one or more years. This emphasizes what we have said many times —that our security lies in an overall protection where one group carries the other from a peak load standpoint. If there is ever to be any improvement in our claim experience it will come through the sincere effort and everlasting vigilance of each and every member of our Medical Society.

SUMMARY

Study No. 1 emphasizes a 30 per cent increase in claims during the past year. High as the increase in the number of claims reported appears to be, the cost of settlement of these claims is far greater.

Study No. 2, on a county basis, calls the attention of the county societies to their respective positions in the general picture. It is hoped that they will use every effort to combat the increased rise in claims.

Study No. 3 shows that all groups of medicine are liable to suit and emphasizes the need of each individual member to endorse the policy of securing his liability coverage in one company so that the premium volume is sufficient to maintain an adequate income to secure liability protection.

Furthermore, your committee recommends that members secure their coverage through the official broker, Faulhaber & Heard, in order that the committee work is concentrated in one office, thus making possible the efforts of the committee to keep adequate statistical data relative to each claim as it occurs.

As your committee has so often said, our greatest security lies in an overall coverage of our entire profession.

For action, see page 20.

MEDICAL TESTIMONY

(Reference Committee "A")

From the Sussex County Medical Society

Whereas, there has been an increasing number of cases regarding medical testimony in recent years with a resulting need for better and closer cooperation between the medical and legal professions;

Whereas, there have been many problems arising, causing a great deal of friction and disharmony between these professions;

Whereas, the solution of these problems is imperative, since in many cases the testimony of a physician is absolutely essential to an attorney in the presentation of his client's case;

Whereas, the aforementioned problems that have created friction between the physician and the attorney have been of deep concern to the members of both professions for a long time;

Whereas, several states, *e.g.* Ohio, Utah, Oregon, and Wisconsin, have adopted codes governing "Standards of Practice Governing Lawyers and Doctors;"

Whereas, the American Medical Association has recently editorialized on these problems (JAMA, April 21, 1956 160:1415);

Whereas, a substantial part of the practice of these two professions is concerned with the problems of persons who are in need of the combined services of both; and that the public interest and individual problems in these circumstances are best served only as a result of the standardized cooperative efforts of all concerned;

Be it therefore hereby resolved, that The Medical Society of New Jersey institute the necessary committee to work in liaison with a committee of the New Jersey State Bar Association to formulate such a code which is to be presented and voted upon at the next annual meeting of this Society.

For action, see page 15.

HOSPITAL SERVICE PLAN MEDICAL SERVICES

(Reference Committee "C")

From the Middlesex County Medical Society

Whereas, it is evident that payment of certain medical services are now incorporated in Blue Cross Hospitalization Plan of New Jersey contracts for direct payment to the subscribing hospitals, and

Whereas, this concept is foreign not only to our ethical principles, but also to those of the American Medical Assocation, therefore,

Be it resolved, that the Middlesex County Medical Society go on record demanding the deletion of such payments for medical services from the Blue Cross Hospitalization Plan of New Jersey and any other statement in the Blue Cross contract implying coverage of medical services; and that such services be included in the Blue Shield Medical-Surgical Plan of New Jersey.

Be it further resolved, that a copy of this resolution be sent to The Medical Society of New Jersey for appropriate action.

For action, see page 19.

MEDICAL-SURGICAL PLAN FORUM

Saturday Evening, May 12, 1956

The Open Forum for Membership Discussion on the Medical-Surgical Plan convened at Haddon Hall on Saturday evening, May 12, 1956, at 8:20 p.m.

PRESIDENT BUTLER: This is an open forum for discussion of the Medical-Surgical Plan. In earlier years large crowds turned out. It would seem as if the same would have occurred this year. Maybe this is a good omen for the Medical-Surgical Plan. Maybe everybody is satisfied. However, the officers and trustees of the Medical-Surgical Plan, and others, are here to be of whatever help they may be to those who have problems or questions. It is not my function to take part in the discussion, but I do want to introduce the President of the Medical-Surgical Plan, who will carry on from here. Let me introduce to you the President, Dr. Royal Schaaf.

DR. SCHAAF: Thank you very much, Dr. Butler.

I am hopeful that the scarcity of persons in the audience indicates, as a whole, some satisfaction with the Medical-Surgical Plan, but I have misgivings on the subject, from previous experience. It looks like the calm before the storm. We expect to hear plenty tomorrow morning in the Reference Committee, but we have always enjoyed these discussions. Out of them has come progressive thinking and improvement in the program of the Medical-Surgical Plan.

Before speaking on the Medical-Surgical Plan, I would like to comment on the fact that the Medical Service Administration, which is the progenitor, or the parent of the Medical-Surgical Plan has just completed fifteen years of service. When we began with the Medical Service Administration, we had a very comprehensive program: a contract for home and office care and hospital care, and an ideal prepayment sickness insurance contract. It was excellent. It was so good we couldn't sell it and after a year of vain effort we abandoned it. We haven't abandoned the plan, but we have abandoned that original contract and we came out with a second contract which was known as Plan Number 2, and that subsequently was detached. It became the Medical-Surgical Plan of New Jersey. Consequently we have the two organizations: the Medical Service Administration and the Medical-Surgical Plan.

The Medical Service Administration still functions. It conducts the Newark Plan. It is presently negotiating for conducting the work of the Essex County Welfare Board in the distribution of payment for medical and associated services, and it is potentially an organization of great value in the distribution of medical care.

We have in the Medical Service Administration only one co-worker who is known as the Administrative Secretary. When there is business of a technical character connected with the office, you are likely to be speaking to her. Mrs. Nugent, please take a bow. She has been with us for six years and is rendering excellent service, and I would like to compliment her. (Applause)

For several years we have been promising you a new contract. We are happy to say that the new contract is now in being. It is being distributed as of May 1, 1956. It represents a great improvement over our previous contract in some ways. In some other respects it still leaves something to be desired.

At previous sessions of the House of Delegates, various proposals were submitted. The planning board was asked to include this and that provision in the contract. As you see the contract, you will note that certain of the provisions were implemented, I think, entirely satisfactorily. Some of them were implemented not so satisfactorily. Some were not implemented at all.

We were asked to apply the income limit to the *combined* income of subscriber and spouse at a level of $5,000. The Board made a long and earnest effort to evolve a new contract introducing that element of combined income. It was necessary to coordinate the opinions of five or six groups of people. These groups include the subscriber himself; his employer; the trade union, if there be one; the doctor; the general public; and, above all of them, the State Department of Banking and Insurance. Sometimes we have some splendid ideas and get them all ready to put into effect. Then the Banking Commissioner says: you can't do that.

We negotiated with the Banking Department for a long time about this "combined income" limit. We finally asked them to suggest a level at which they would be willing to approve a contract for combined income of subscriber and spouse. The attitude of the Department of Banking and Insurance was that to apply the combined income at the $5,000 level would represent a very distinct reduction in benefits. Their position was to accept no change in the contract if it represented a reduction in the benefits. We finally persuaded them to tell us what was the minimum level at which they would approve a combined income of subscriber and spouse. Rather reluctantly they hinted that they might consider an income of $7,500.

We took that to the Board of Trustees last winter. They, seeing the difficulties with which the Plan was confronted and the need for recognizing the combined income of subscriber and spouse as an actual fact, agreed to let th Plan offer a contract with a combined incom of $7,500, with the single person's contract t remain at $5,000.

One of the other things that we were urge to do was to eliminate from the existing con tract provision for pre-natal and post-nata care. We took that to the Department of Bank ing and Insurance. They regarded that pro posal as a reduction of benefits and decline to approve it. We had to leave it in the con tract. Thus we were legally unable to carr out the directive of the House of Delegate in that respect.

One of the other things that we were un able to do completely was to eliminate consul tations from the contract. We finally won th approval of the Banking Department to limi the consultations to one per admission.

There was great pressure brought upon u to include coverage for radiation therapy out side of hospital. There was great pressure pu on us to include all types of office surgery There were a few other pressures which w were unable to respond to.

There are some sound reasons for non-in clusion. First, there is only so much money i the contract rate for distribution in as wide a range of services as possible and in as equit able a manner as possible. If we include al these additional services—radiation therapy or diagnostic x-ray in office, surgery of all kinds in office, and other desirable benefits—it would raise the cost of the premium to such a level that it would make the program unsalable. It is better to have a half a loaf than no bread. So, very reluctantly, we had *not* included those desirable things. However, they are not finally and definitively excluded. We are presently negotiating with the Department of Banking and Insurance to find out whether they will permit us to issue a rider which would offer additional benefits for additional premium rates. That negotiation is still pending. We are not certain whether the Department will consent to additional benefits by rider. They have it under serious consideration. If their decision is favorable we will have available two or three levels of policies that will fill the needs for benefits not presently covered.

There are some compensating advantages in the contract. We have substantially increased the number of medical days. We restored the cuts made in certain surgical services back in 1952 when demands on the Plan were excessive. We increased the availability of surgical coverage so that all services presently payable under the old contract in bed care at hospital became payable in the out-patient de-

partment. That in itself represents a very great expansion of benefits.

If you are interested in asking questions about the Hospital Service Plan of New Jersey, we have its Vice-President and Executive Director with us. Mr. Durgom has been here frequently in the past. He came down for this meeting and will attend the Reference Committee tomorrow. Will you take a bow Mr. Durgom? (Applause)

Mr. Durgom has been a very valuable part of the Medical-Surgical Plan even though he is not officially part of our staff. He has managed the sales campaign, and he is a superb salesman. In addition, until recently he managed all of the business of our Plan; that is, the collecting and the tabulations and the solicitations, and so on. So he has made a tremendous contribution, in fact he and the late Theodore Sorg were the backbone of our Plan in its early days in both an advisory and in an administrative capacity. The physicians and the people of New Jersey should be grateful to the Hospital Plan for the contributions made not only to the distribution of *hospital* care, but, less directly for their role in the distribution of *medical* care.

MEMBER: Dr. Schaaf, originally the plan was to provide coverage for low income groups. Is that correct?

DR. SCHAAF: That was the original conception. It was on that basis that the Medical Service Administration was founded. As time went on, we were reluctantly forced to the conclusion that the distribution of medical care to low income people on a pre-payment insurance basis was not practicable. We branched out into the more general coverage. Low income coverage is not an insurable risk even today.

MEMBER: Does this mean that the objectives of the Plan now are different from what they started out to be?

DR. SCHAAF: Prepaid sickness insurance is like any other type of insurance. People who can afford to pay premiums on fire insurance, do so, as they do with premiums on life insurance. By payment of insurance you establish a fund against which you may draw should the need arise.

This is quite different from the distribution cost of medical care. That is handled on a *reimbursement* basis. The cost is incurred and then the agency reimburses the doctors or whomever may be entitled to payment. But this is entirely different from the original approach. Actually, low cost care to indigent patients is not feasible.

MEMBER: The Plan was set up not to furnish care for indigent, but to furnish care for individuals who had a catastrophic illness for which they could not afford to pay.

DR. SCHAAF: That's right.

MEMBER: Are you planning a real "catastrophic illness" policy?

DR. SCHAAF: Our definition of a "catastrophic illness" was established by this body fifteen years ago. It is any illness which necessitates hospitalization. If you are speaking of a long-term illness like infantile paralysis, tuberculosis or mental disease, or diabetes, that is a little different from "catastrophic." Long term disability has to be handled on a different basis. It is doubtful whether these long term illnesses can be adequately handled on an insurance basis. With a certain premium rate we can pick up insurance against a long term illness which had not occurred, but you cannot insure a person who is already undergoing a catastrophy. That is not an insurable risk. You can't insure against any catastrophy that has already happened.

Insurance presupposes the payment into the fund of a given amount of money against which drafts may be made for certain types of losses. Some people are uninsurable. That is true if the subscriber has no income or funds with which to purchase premiums; also elderly people because of the high morbidity among the elderly. Also because many don't have income and they can't pay the premiums. The chronic ill are not insurable. Unemployable people are uninsurable. Either they don't have the income or their health condition is already a hazard. Uninsurable people, whether indigent or not, must be handled on a different basis than insurable people.

The Administration in Washington is advocating re-insurance as a basis for the care of the chronic ill. This is unrealistic. It is visionary. They want to do secondarily by insurance what can't be done primarily by insurance. On that basis the American Medical Association has opposed it. On that basis, commercial insurance companies have opposed it. It is not practical in this state, for example, to limit our plan to operating with recognized losses, which is what this re-insurance program contemplates. The Banking Commissioner would put us out of business. It is not a simple matter. This national picture has been developed by people of very good will, but not too much knowledge about insurance.

DR. JOHN F. JOHNSON (Trenton): Dr. Schaaf, I think it is worthwhile to look into how insurance plans affect our practice. And after all, the reason we initially resisted insurance plans was that we felt that our American plan of medical practice was the best in the world. Now, it may be a little too far-

sighted to fear that insurance plans could change our means of practice. But let me point out a few things which, under our own direction, have crept into the practice of medicine.

First: we pay hospitals, under Blue Cross, fees for services rendered by doctors. That's a change in our manner of practice of medicine.

Second: We propose to pay this year, a fee up to $50 for pre- and postoperative care of surgical patients. This has been stigmatized as "division of fees." Let's not castigate it as such. But it *is* a change in the manner of the practice of medicine.

Third: So far as income level is concerned, we keep looking up. We think of the patient who has $5,000 or more. But anybody who has done general practice will scale down his fees according to the number of dependents which this supporter of a family may have. I think the Medical-Surgical Plan and the Blue Cross of New Jersey had a complete blind spot from the $5,000 level down. Now they talk about the $7,500 total income. That doesn't mean a thing, it really doesn't, when you consider how many are dependent upon the $5,000 income or the $7,500 income.

Six years ago, we in Mercer County suggested that there could be a scaling down of the cost of insurance to a man who has a $5,000 income with five or six children; and conversely a different basis for the single man. The doctor should have a higher fee for services to a single man.

I have checked our Delegates and I have been asked to say this: We are unalterably opposed to the payment to hospitals for services rendered by physicians.

We are strongly opposed to the division of fees for pre- and postoperative care. If a doctor is deserving of a fee, let him bill the patient. If the patient can't pay, let the surgeon have that as part of his conscience, providing the income producer of that family has an insurance plan. Let us not formalize that relation. Yet that is what we are trying to do. And that is where we are changing the practice of medicine in this country. We are trying to formalize it. We can't do it.

Now, I would suggest for the consideration of this group on an informal basis that we think back as to why the Blue Cross and Blue Shield were started. It was purely a political move on our part.

DR. SCHAAF: Would you define what you mean by a "political move on our part"?

DR. JOHNSON: We were on the spot from 1942 on. On the spot, politically, for socialized medicine throughout the country. Now, the thing which we did not like about socialized medicine was that we did not want to change the type of practice of medicine which we have in the United States. This has proved to be the most rewarding for the physician and best, and least expensive for the average citizen.

We didn't get behind any political bandwagon then. We figured out in New Jersey one of the best plans in the country.

DR. SCHAAF: Glad to hear that. I think so too.

DR. JOHNSON: It really is. I was on the Insurance Committee for Mercer County for three years and we analyzed some eight different states' plans.

But let's not lose sight of our objective. We don't want to change the manner in which we practice medicine. Do not force us to split fees. Do not force us to one consultation when the patient is in the hospital. If the Plan has to yield a little bit this way or a little bit that way, let's not make it too rigid.

Now, politically, to answer your question, this a stop-gap against State Medicine in New Jersey. It has been very effective.

DR. SCHAAF: Stop-gap against what?

DR. JOHNSON: Socialized medicine or any tax-supported program of medicine. But this should not change our manner of practice of medicine. We are losing sight of the main objective because this has been injected in a turbulent period and we are watching this little change that has occurred. But let's keep practicing medicine the way it has been so successfully done in the United States.

DR. SCHAAF: I am grateful to Dr. Johnson. He has given me an opportunity to speak on a number of topics. In the field of logic, you know you want to be wary of that first premise. If you grant the first premise, the good logician can take you anywhere. I am unwilling to grant some of Dr. Johnson's major premises.

He starts out stating that he objects to the Blue Cross and Blue Shield paying for medical services to hospitals. Blue Shield does not pay anything to hospitals. Blue Cross does not pay anything to hospitals except hospital charges. I agree that practitioners of pathology, physiotherapy and roentgenology are specialists in the practice of medicine. I think however, that the situation which has grown up is one that has been evolutionary in the last half century. We are now trying to break down something which has grown up and has become granite-like in structure.

There are certain services which hospital administrators, hospital trustees, the general public, and even some doctors think are hospital services. Two years ago our Plan offered a resolution, which was approved by this

House, relating to an attempt to break down that part of hospital charges which are for hospital technical service and that part which represent professional services. I speak particularly of roentgenology and pathology. Anesthesiology is broken down now. Anesthesiologists, for the most part are not on salary. They are sending bills for their services.

The complaint is not against Blue Cross for this. All the Blue Cross does is have a contract with the hospital to pay them its *per diem* cost for the services it renders. What goes into that *per diem* may be scrutinized by Blue Cross for one reason or another—depreciation charges and so on. But for practical purposes all of the stated cost of the hospital is lumped into one sum; and that is divided. You get a *per diem* rate and the Hospital Plan pays that. So that complaint shouldn't be against the Hospital Plan.

Now, there is a complaint against the Medical-Surgical Plan, and you heard one of them this afternoon in a resolution about medical fees as distinct from surgical fees. Our Board is completely in accord with the idea. But this is not *our* failing; it is not our responsibility. The Plan is operating within the existing pattern of the medical practice. Unfortunately, the surgeon who does an appendectomy is considered a more brilliant fellow than the skilled cardiologist who saves you when you have a coronary. But that has nothing to do with the Plan; that is the general pattern of medical practice. The surgeon is dramatic. The medical man might save your life, but he is not quite so dramatic in the public eye. This is not a just criticism of the Medical-Surgical Plan.

We have been asked to pay for medical cases on a "package" basis. If we did, Blue Shield would be the only people who would pay for medical services (as distinct from surgical services) on a "package" basis because that isn't the way physicians charge. They charge on a *per diem*, consultation, or fee for service basis.

What we are trying to do is to cope with changed conditions today. Blue Cross began twenty years ago because there was a desperate need. Hospitals had no money; they had to be maintained. So in the period from 1932 to 1940, the only thing that kept the hospitals going was the Hospital Plan. In the past 30 or 40 years, there have been substantial changes in the face of medical practice. The most radical change has been in the attitude of the doctor himself in his relationship with his patient. Today, there may be more interest in the financial return for service rather than the service itself. Blue Shield is not responsible for that. It is an evolutionary change dependent upon our changing economic conditions and the less intimate relationship between physicians and patients.

Today it is unusual for a family to have the same doctor over a period of years. This is largely because they move from one place to another. Or they get piqued at one thing or another. Such factors have altered the practice of medicine. But it isn't because of Blue Cross or Blue Shield.

The economics of medicine, both for the people and for the doctor, are enormously better and enormously changed from what they were twenty-five years ago. The economic condition of the patient (so far as paying for hospital and medical care is concerned) is so much better than it used to be that, in all but the large municipal hospitals, the complaint is that: we have so few patients upon whom we can let our resident staff get their training. Dr. Behr of Mount Sinai told me in 1947 there are so many people now covered by one form of insurance or another in their hospital and medical care that there are practically no "free" cases. The census of the Martland Medical Center today is less than it used to be in 1925 when it was the Newark City Hospital and I was Dr. Sprague's assistant. We had a terrific service. You don't have anything like that now. Why? Everybody is working and/or insured. The insurance may be commercial, it may be Blue Shield, it may be something else; but they have it and you don't see so much destitution. They've got the insurance, and I think it is a tremendous benefit to the people; second, to the communities; and third to the doctor. Prepaid voluntary sickness insurance has revolutionized the economics of the average doctor's practice. There is a city in this state with a high proportion of its citizens in a low economic bracket. Most of them work for certain large industries as laborers. The doctors in that community formerly did all their local work practically on a free basis, as did the local hospitals. Today the services are being paid for by the employer, for the most part. You now have financial provision for hospital and medical care that twenty-five years ago was never even dreamed of.

Perhaps you say that that is not progress. Maybe you like the old system of the rich man paying the freight for the poor man. But that is disappearing. This is now the thinking of our State Department of Banking and Insurance. We had in mind a plan to have a low premium rate with a lower schedule of benefits applicable to people of lower incomes. We took just that to the Banking Department and they threw it out. They said: Doctor, you can talk from now until tomorrow, but you cannot

convince us that there is any justice in two levels of fees for the same service.

When you get that type of thinking on high government level, we've got to revise our own thinking. You can't conduct your practice as you did, as we did thirty years ago when we did a lot of free work for which we got very little or nothing; and then got bigger fees from an occasional patient. The rich man was carrying the load for the poor. Today you get paid for most of your work. I will certainly agree that practice is changing. I think for the better.

You spoke of the political implications of this. Were voluntary prepaid sickness insurance not in being in its effective state as at the moment, we would have had socialized medicine, with all of its drawbacks, ten years ago. We almost got it in 1945. And what would have been objectionable about socialized medicine was the "compulsory" component.

Financially many of us would be better off on a system of guaranteed payment for certain annual service. But it has been the experience of every nation that has had socialized medicine that the standard of medical practice deteriorates. The good standard is pulled down to the bad; the bad is not pulled up to the good. It is all to the good that we have forestalled the inequities of socialized medicine. If we have done nothing else, I will accept that it was a good plan.

MEMBER: Dr. Schaaf, I noticed you said something about small procedures in the office. You did not at this time feel that it should be covered. It's annoying to me to go up to my institution and see on the operating room schedule a ganglion of the left wrist or a sebaceous cyst of the scalp. I look over my own list of operative procedures and find I can't get a gall bladder case into the hospital. I have to wait four or five weeks because of these numerous minor procedures. We used to do these in the office. I mean lipomas, sebaceous cysts, ganglia, and so on. Now, when the patient comes in, if he has your Plan, he says: Doctor, you are a good guy, but, you know, I have been in this Plan for a couple years and you are not going to take this out in the office because I won't get reimbursed. Therefore, I will allow you to do this for me if you take me to the hospital. As a result, minor surgery has cluttered our hospitals. It is difficult to get room.

If these minor procedures would be reimbursed if done in the office, you would save money on hospital fees. You would save money on the operating room. If you would allow the physician to take out a cyst, a ganglion, an ingrown toenail in the office, you would save a lot of money. You'd also not clutter up our hospitals.

DR. SCHAAF: In some respects you are right. We have made partial effort to accomplish just what you want. We now cover in the out-patient department, payment for any service which is now available for payment in the hospital.

But if we increase the benefits to the extent of paying for *all* office surgery, we will have a prohibitive increase in our costs. It will raise the premium rate to a point which will almost make it unsalable. And, after all, you have to think what you are trying to do with insurance.

If we were certain that we were not going to have a fire that would cost us more than $25, we wouldn't take out fire insurance. If we were certain we were not going to have a collision of more than $50 on our automobiles, we wouldn't take out collision damage. And if we were only going to have a boil opened or a cyst removed, we are not going to take out insurance because we can pay the small fee ourselves.

In other words, you can't insure against every hazard, or you shouldn't try to. We have a fair compromise by making eligible for payment any service in the out-patient department which is now eligible to the in-patient. That would eliminate the proper complaint that too many minor cases are taking up too many beds. I agree with that. But there are other aspects besides the cost. We can't control the incidence of office surgery.

MEMBER: You mentioned the impracticability of having two schedules of payments. But we certainly have two schedules: one surgical and one medical.

DR. SCHAAF: Not for the same service.

MEMBER: You say you can't afford to take care of these major medical problems. Yet there has been a progressive increase in surgical fees. There is now pre- and postoperative care now coming out of what was the surgical fee before. Are the figures available on what proportion of payments are for medical cases and what for surgical? Does Dr. Borsher have the figures?

DR. IRVING P. BORSHER: The percentage of payment for obstetrical services in relation to the payment for all services under the family contract is 24 per cent. This does not include the services rendered the infant. It does not include anesthesia in the obstetrical cases. It does not include consultations in obstetrical cases. Surgical payments account for between 55 and 60 per cent. This refers to all contracts, not just the family contract. And medi-

cal payments make up about 20 per cent of the total payments.

MEMBER: May I ask Dr. Borsher to break down the surgical payments? Is that just for surgery or is that surgery and all the surgical specialties? Does it include anesthesia, urology, orthopedic surgery, neuro-surgery and otolaryngology? Or is it just straight general surgery?

DR. BORSHER: That is the payments for all surgical procedures, not including anesthesia. Anesthesia currently is in the ratio of six per cent of the total payments for all services. The figure on the surgery includes all payments for surgical services. It does not include obstetrical and it does not include payments for medical services. It includes gynecologic surgery.

DR. WILLEY: If I were running the Medical-Surgical Plan I would deal only with industry. Can Mr. Durgom tell us what proportion of your income comes from your contracts let to industry as a fringe benefit on their negotiations?

MR. J. ALBERT DURGOM: There are 4,000 industries now enrolled as groups through the Blue Shield Plan. They account for 35 per cent of the 1,500,000 enrolled in the Blue Shield Plan. About one-half of those 4,000 companies are covered by the employer making the contribution towards the contract rate. One-half of those are paid *in full* by the employers. On the other half, the employer pays part and the employees pay part. The trend is toward employer contribution of the entire contract rate for his entire personnel and their family dependents. If now the employer pays only part, it is one of those evolutionary developments through subsequent years of negotiations between labor and management. It is only a matter of time. About 80 per cent of all people covered by Blue Shield and parallel Blue Cross will be covered by the employer paying the entire contract rate.

MEMBER: Will the Banking and Insurance Commission permit you to write a different contract for that type of premium? The one fault I find with the Medical-Surgical Plan is that so many of my patients are not covered; they cannot be covered.

DR. SCHAAF: You are talking about individual or direct enrollment.

MR. DURGOM: It is expected by action of the Board of Trustees of the Blue Shield Plan in its direction to the Blue Cross Plan, that in about October 1956 ways and means will be set up for non-group enrollment under the Blue Shield Plan for qualified individuals who cannot enroll through a place of employment.

DR. SCHAAF: One point about the direct enrollment is that there are different underwriting principles for the individual as compared to the group. We have to have a very good family history, personal history as to pre-existing conditions and we have to have certain exclusion clauses and protective clauses in the contract. But the selection against the Plan would be terrific if we didn't have a measure of control.

We hoped originally to launch both the group contract and the direct enrollment individual contract at the same time, but it was administratively impossible to set up the mechanism. We had to get one of them "in being" and then offer the other a little bit later.

DR. WILLEY: You brought up the problem of a policy with an over-rider. Haven't you reached the point where you might have more than one type of policy?

DR. SCHAAF: We hope to receive permission from the Department of Banking and Insurance to use our present contract as the basic contract to which can be added additional benefits with additional premium rates. But the Banking Department has not yet given us this permission. If we had that authority, the possibilities of different policies would be infinite. For practical purposes, we should boil it down to two or three, but you could do almost anything on a rider basis that you wanted to do. There is only this catch in it; that if you issued any kind of a policy it must be available to anybody who wants to buy it. You can't develop a tailored policy for one company unless you make that available to anybody else who wants to buy it. So for practical purposes we might have two or three varieties of policy on a rider basis or an additional contract.

MEMBER: Could Dr. Borsher give the *amounts of money* paid to surgical cases as opposed to medical cases?

DR. BORSHER: Obstetrical cases approximate 16 per cent of all cases. They are related to all contracts not just the family contract. The amount percentagewise for the first three months of this year was 24 per cent. Additional services in those obstetrical cases of a surgical, medical or consultative nature accounted for an additional per cent. So in obstetrical cases it was roughly 25 per cent of the payments.

In the surgical cases, which were about 40 or 45 per cent of all cases, the ratio of total payments was 45 per cent. Secondary services in those cases were 4.3 per cent.

Medical cases, which were about 20 per cent of the admissions, accounted for 18 per cent of the total payments for the first three months. The secondary services in the medical cases, in-

cluding consultations, was an additional 3½ per cent. Anesthesia represented 6 per cent of the total payments.

To summarize the percentage of payments; 25 per cent in obstetrical cases; 50 per cent in surgical cases; 19 per cent in medical cases; and 6 per cent anesthesia. As to numbers of cases here are the figures: obstetrical cases, 8,394 for the first quarter of this year; surgical cases, 24,411; medical cases, 12,482; that's 45,000 cases. Now 3,000 into 45,000 is roughly about 18 or 20 per cent in obstetrics; the surgical cases would be 30 per cent; the medical cases about 22 per cent.

MEMBER: Is there a continued exodus of participating physicians from the Plan? What would you consider the common reasons for leaving? And what has the Board done in trying to regain them? Have they been convinced that direct payment to subscribers treated by these non-participating doctors is not a punitive action toward them but rather a "reward" for physicians who are still participating?

DR. SCHAAF: It's an astonishingly small number; less than 1 per cent of our group a year.

DR. BORSHER: That's right. Out of some 5300 physicians we lose about 28 to 30 a year by resignation—actually about 6 tenths of one per cent. In the last ten years, there were some 400 separations of participating physicians. But 112 of these were out-of-state doctors whose eligibility had to be subsequently withdrawn. The voluntary resignations totalled 288 in ten years, an average of, say, 29 a year.

In New Jersey there are 6720 doctors licensed to practice medicine. And 5381 are participating physicians. That means over 80 per cent, assuming all the 6720 are in private practice. Of course, some of them are in full-time institution or agency work, so the ratio is even higher than this 80 per cent.

DR. SCHAAF: You wanted to know the reasons for resignations, too. I know one thing that led to some resignations was our inability to use the $5000 level for the combined income of subscriber and spouse.

Among specialist obstetricians, a number of them left us because of the inclusion of the pre-natal care in the fee we were paying. It was regarded as inadequate. They urged us to eliminate it.

Anesthesiologists are poor participants. They want a high return for their services. We perfected a very good fee relationship between surgeon and anesthesiologist in the present schedule. Some of the anesthesiologists have come back.

There are some bizarre reasons for quitting. I know one surgeon who left us in a huff because we paid $75 for a ligation of the internal saphenous vein. He thought he ought to get $125. He left us on a single fee.

There was a question about the "punitive" character of the direct payment to the subscriber in the case of non-participating physicians. We have never regarded it as "punitive." We adopted the present practice at the behest of this House of Delegates who were insistent that there should be some compensating advantage to being a participating physician. They regarded direct payment to them as a compensating advantage. Our relationship with non-participating physicians is exactly the same as the relationship of the participating physician with the commercial insurance companies. It is possible in certain circumstances to have the benefits assigned to the surgeon. But, by and large, surgical payments for services made by commercial insurance companies are made to the subscribers. They pay the doctor part of it. The non-participating physician is no worse off with us than he is in his relationship with the commercial insurance companies.

DR. GERARD R. GESSNER (Middlesex): Has the Plan ever considered a $50 deductible insurance item? I speak mainly about those who want to go into the hospital for gastro-intestinal or gall bladder series. We seem to have sold the public the idea that any sort of an illness, not catastrophic, would be taken care of by the Plan. Have you ever considered the first $50 deductible and from there on in let them take care of it?

DR. SCHAAF: We have considered it very seriously and have not accepted it. To do so would convert the Plan from a service benefit to an indemnity plan. There is no excuse for doctors being in the business unless it is a service benefit plan. The commercial insurance companies on an indemnity basis can do a better job than we can do. It just doesn't work.

The Hospital Plan specifically excludes payment when patients are admitted primarily for diagnosis. That service is an uninsurable risk. You can't predict the need for diagnostic service. If it is available, everybody is going to get it. It just isn't actuarially feasible to compute it. You could compute it on an indemnity basis, but you'd have the same problem of being an indemnity instead of a service plan.

DR. GESSNER: I'm the representative of the Middlesex County Society. That's why I'm asking. These questions came up at our County meeting. Married couples may have two plans. They have one with the Medical-Surgical Plan. Perhaps one spouse is in another institution or

industry and they have their own plan. Now, they collect from two plans.

This doctor stated that he gave the patient a figure for a certain operative procedure. Then the individual came in with the Medical-Surgical Plan and he filled out the form and sent it in stating what his fee was and that he had been paid; Medical-Surgical paid $50. Now, this subscriber had paid the doctor $80. They wrote back to the Medical-Surgical Plan and now the Plan in turn wrote back to the doctor, and so the doctor stated that he should return the $30 to the patient. What are you going to do in those cases?

DR. SCHAAF: Well, under the new contract a great deal of that complaint will have been eliminated. Double coverage is what we call that situation. It occurs when both husband and wife are working. The inequity against the doctor was manifest most when the wife was a subscriber and her income was below $5,000, and she was married to a man perhaps who was making $15,000 or $20,000. That was a grave inequity.

But under the new contract you have the combined income of subscriber and spouse. Under present working conditions, the combined income of two people working is almost certain to be above $7,500, after which this payment made by the Plan is a payment on account and the doctor can send a supplemental bill.

DR. GESSNER: Let us assume that the combined payment will not be $7,500. Can the doctor go ahead and charge the individual when they have double insurance?

DR. SCHAAF: No, he may not. The reason is this: there seems to be an inequity about it, but it stems from what is "income," and in the eyes of the Income Tax Department benefits paid for illness are not income, so you can't say that. We have gone into that. Legally it is not income and therefore the $5,000 prevails even though they get double payments.

DR. GESSNER: What will you do in case of a law suit if a doctor makes an agreement with the patient, then the patient reneges, gets a larger sum in settlement. What can a doctor do in that case?

DR. SCHAAF: As you know, a lien law has been in existence for many years in this state. If you have an accident case against a third party, the doctor can place a lien against the settlement.

Now, the orthopedists and the traumatic surgeons had several conferences with us asking us to eliminate coverage for accidental injuries by third party actions, from our Plan. We gave it very serious consideration and we had leading men at the conference. When we demonstrated that under the lien law the highest hospital payment made to any hospital was about 27 per cent and to the doctor was about 25 per cent, they said: leave it alone. That was the orthopedists and traumatic surgeons. Although they came insisting that we delete it from the program, when they actually had the statistics that we could make available to them, they said: leave it.

Those are inequities, to be sure, but they are not completely controllable and we don't know how to eliminate that particular kind of a thing.

DR. GESSNER: Why can't you put on these white cards just what the income of the family is, because patients will go ahead and tell you different sums rather than tell you what they actually make.

DR. SCHAAF: As a plan, we wouldn't possibly be able to keep that up because income, particularly when it was on the $5,000 level may be up or down from week to week, and what was good today wouldn't be good next week; next week the income would be $6,000 a year, and you see it just isn't practical. We have offered to check the income of questionable cases and we have found that the subscriber's statement as to his income tallies very closely with the statement we get from his employer. In 90 per cent, there is no difference. There is a certain amount of chiseling. You will never prevent it all.

Some years ago I was in a conference with the late Edward Bamberger. We were worrying about this problem and that problem and finally I said: "Well, the truth is that there is ten per cent of chiseling in every walk of life and you can't eliminate it." And a twinkle came in Mr. Bamberger's eyes. He said: "Doctor, you are wrong; the figure is twelve per cent."

DR. GESSNER: I don't blame Mercer County for still trying to prevent the so-called "splitting" of fees. But we are a democratic organization and the vast majority of all the physicians in New Jersey, outside of Mercer County, were in favor of having that fee paid to the assistant. If you don't want to pay the assistant, you want the assistant to go ahead and charge an extra fee, what are you going to do in that family where they have five children? I'd like also to know when his wife goes into a grocery store, do they ask his wife what her husband makes? Do they charge him extra for the butter, bread or anything else? I am a general practitioner and not a surgeon.

MEMBER: In a liability case, where two physicians are involved and the Blue Shield pays for the services of one in full and for the services of the second in part, what is the po-

sition of the second physician so far as collecting the balance? For instance, the second physician was required to see the patient daily for ten days. The fee paid by the plan was $30, presumably on some calculation of consultations. There were services of a general nature and a special nature. Special services for the ten days, the fee was $30. It was a liability case. Is the balance collectible from the patient? Remember—one doctor took care of the patient for a concussion.

DR. SCHAAF: What was the accident?

QUESTION: A man fell, struck his head and injured his eye. He had a general practitioner and an ophthalmologist. The ophthalmologist got the $30.

DR. SCHAAF: Well, he got two consultations, which is all we could pay for one consultant and one admission.

MEMBER: Are the services of the ophthalmologist to be written off by his contract with the Plan or are they uncovered services for which he may collect?

DR. BORSHER: My answer is going to be based on the assumption that in this case there was an attending physician and a consultant. I believe there was mention that the case was hospitalized for ten days.

MEMBER: Yes. The attending physician requested the ophthalmologist to assume full responsibility and continuous attendance for the eye condition only.

DR. BORSHER: And what did the attending physician do?

MEMBER: Assumed responsibility for the patient generally.

DR. BORSHER: And the attending physician submitted a service report to the Plan on the basis of being attending physician for ten days. Well, under the terms of the subscription contract, the Plan cannot pay for the services of more than one attending physician on any one day. So that the attending physician submitting the claim as attending physician for the ten days placed the ophthalmologist completely in the classification of a consultant. And in the classification of consultant the Plan, by regulation, limits payment to two consultations to any one physician and any additional consultations rendered by that consultant during that period of hospitalization or during the eligible period of hospitalization up to 21 days. Any other consultation rendered by that consultant, the Plan payment for the two consultations includes those. Now, that's under the 1949 series contract.

Under the 1956, the new contract which is being issued next week, the contract limits the Plan payment to one eligible consultation per admission. So that any additional consultations which are requested and written by the consultant, the patient will be responsible for those consultations and he can bill them.

MEMBER: It frequently occurs that a patient requires the services of an attending physician for a medical condition for more than two days. At the same time, he is under the care of a surgeon. I have been advised that the internist's bill is paid in full.

DR. BORSHER: In surgical cases, the surgeon includes the services rendered for the operative procedure and the postoperative care and pre-operative care within 48 hours of the operative procedure. Now, there is eligible for payment in the surgical case, medical services rendered for a complicating medical condition which is *not* incident to or related to the surgical procedure. In a case like that, there is a surgeon and there may be an attending physician who renders the medical services for the complicating medical condition *not* related to the surgical procedure, and there also may be basis for payment for consultation.

DR. GESSNER: Let's turn that cart around. The previous doctor may learn a few things in this lesson. Whether you are the attending physician and you have a qualified specialist take care of it, you are still responsible. I can cite a case where I had somebody with a fracture of the tibia. I had an orthopedist take care of it. He also had a tearing of the tibial artery which was not recognized. Textbooks state that, no matter what therapy you use, seven out of ten lose the leg. And though it was under the specialist's care and I was just the referring physician, you come in, you see your own patient. That's what the G.P. does, whether they have the best surgeons or any specialists, the G.P. always comes in. I was sued for $400,000. The verdict was in my favor. I was ruled "not liable." The surgeon had a verdict of $125,000 against him. So whether you charge or not, you are going to be held responsible just the same.

MEMBER: Dr. Schaaf, you said that the Plan recognizes that there is perhaps some inequity in the treatment of the medical man. Certainly, aside from the general practitioner, the medical man doesn't get an equitable break with the surgeon in the Medical-Surgical contracts.

You intimated that the Medical-Surgical Plan, as it is now constituted, is a matter of tradition and general policy in the establishment of fees and that the Plan is not responsible for this inequity. Yet since the medical man cannot deal with the patient directly when they carry insurance, how else can the medical man get equity in this without dealing with the Plan? You can't deal with the patient a

you did before when they didn't have insurance.

DR. SCHAAF: You are raising a question about the difference between payments to general practitioners and payments to specialists in internal medicine. Much time and thought have been devoted to that problem. We have repeatedly asked The Medical Society of New Jersey to give us criteria on which we can judge the qualifications of the specialists and know to whom we could make payments properly as specialists. The Medical Society has declined to do it. The Plan simply cannot distinguish between grades of medical service. An appendix removed by me is the same as an appendix by Comando, by Sprague, by Frank Lahey or Charley Mayo. It's the same fee for the same service. We can't distinguish between the value of medical service as opposed to surgical service when rendered by the general practitioner or when rendered by the specialist. It is a problem that the Plan doesn't control.

Now, if we could get the principle established that there were different grades of medical service and have it accepted by the Department of Banking and Insurance, we might be able to cope with it. But the Banking Department will not accept the thesis that there should be a different level of payment for the same service.

MEMBER: That is one part of it. The other aspect is the payment of medical cases on a *per case* basis rather than a *per diem* basis. This would be more equitable and would treat both the medical man and surgeon alike.

DR. SCHAAF: We have tried—that comes under the category of "packaging" medical illnesses. Coronary thrombosis is "X" dollars for "X" length of stay; pneumonia is "X" dollars for "X" length of stay, and so on. We thought that we could develop a group of cases on an experimental basis, at least, which we could try to pay in that manner. It wasn't long before the list became totally unwieldy. We had so many different "packages" offered that we couldn't cope with it.

Now, we will cope with anything if it is a practical problem to cope with it. After all, there are certain almost insurmountable difficulties particularly when you are met by the Banking Department with the statement that there can be no difference in payment for the same service. That is really bad; that's really a stymie.

DR. JOHNSON: The Medical-Surgical Plan, Blue Shield and Blue Cross, involve the *economics* of medicine. That is one feature of the practice of medicine. The other is the *manner* of practice of medicine. Don't confuse the two. I ask the doctor from Middlesex County: what does he do about the patient who has no insurance but who is able to pay in a similar situation where a general practitioner renders services prior to surgery. He has a surgeon do the operation. He may take care of the patient afterwards; he may or may not, depending upon the situation.

I don't think that we should confuse just what Blue Cross and Blue Shield does in New Jersey at least. It is purely an economic plan which makes the cost of medical care bearable to the middle income group. The problem is not in the low income and it's not in the high income group; it's in the middle income group and for that middle income group this plan was devised. We conceded we got a concession that we were the third person in an insurance policy. We were paid directly by somebody else who paid premiums to "A," and "A" paid "B," us.

The "punitive" measure does not belong in this proceeding. Let's not change the way we practice medicine. It may be something for you to think about tonight. We've got to talk about this tomorrow. Let's keep our practice of medicine the same. Let's not split fees, whether it is legal or not.

DR. SCHAAF: Dr. Johnson asked a question which we didn't answer. A doctor is not barred from billing for anything which we do not pay for under our contract, such as the services of another physician. What we don't pay for, the doctor can bill directly.

Of all the problems we have had, the most difficult, the most persistent, the most discouraging has been the question of compensating the doctor who renders elaborate service in the care of a patient—the general practitioner who does certain things in a surgical case. He should be compensated. This is not fee splitting. We felt that a mechanism could be devised which would meet all the ethical requirements, and we have had before this house three or four successive years—I'm sure it is going to come up again tomorrow, although we think, so far as we can go, it is settled. Indeed, we actually went to the length of developing a resolution which was introduced by our Delegate to the American Medical Association. It will be two years in June. It was passed and I would like to read it. It is in the May JOURNAL and it relates to apportionment of the surgical benefits. You will find it on the top of page 282. It has been approved by the American Medical Association as being entirely within the ethical concepts of that association. When I said that so far as we were concerned we were through with it, I meant the general provisions. It is there by

direction of this body, and until we render a new contract it is going to have to stay there. It just can't be changed.

While this mechanism is available, it doesn't have to be used. Any hospital can avoid it by simply telling its staff members: we don't want anybody to avail themselves of that apportionment of available surgical benefits. There is no problem unless the Plan gets a claim. The Plan won't get a claim from a hospital that disapproves of it.

If Mercer County disapproves of it, we won't get a claim from Mercer County, so it won't interfere with your pattern of practice in Mercer County.

And no matter what the personal ideas of the members of the Board may be we have repeatedly had directives from this body to bring about a mechanism which would recognize the contribution of somebody other than the surgeon to the care of a patient in a surgical condition. We think we have done it. If a certain hospital doesn't want its surgeons to avail themselves of this mechanism, they can vote a staff resolution against it.

It is certainly within the ethical concept of the A.M.A. They actually adopted a resolution for it. I think it is hypercritical to keep accusing the Plan of fee splitting The highest ethical body in the United States says it is not.

DR. SALVATI (Union County): I wish to express my appreciation, and I'm sure the rest of this noble body has the same thought in mind, for the wonderful work you are doing for the Society.

DR. SCHAAF: Doctor, I'm very grateful and I accept your complimentary compliments, on behalf of the Board, because I am merely their mouthpiece. We have picked each other's brains for years, and any other member of the Board who got up here, I think, would give you substantially the same reply. I mean we think like a machine.

And I'm grateful to Dr. Johnson. Really, I enjoy forensic debate. With me it is always on an intellectual level. I don't get emotional about it. I don't think anybody is personally critical of me or personally critical of any member of the Board, and I'm sure that that is the right attitude.

We certainly appreciate your coming, and we will be around tomorrow if you want to throw brickbats at the Reference Committee. Thank you very much.

MEMBER: I have a question I would like to get clear because of the wording of the new contract. It says: " . . . for patients who would otherwise be eligible to bed care." Would that mean, then, a general practitioner who would perhaps want to remove a wen, the same as a surgeon, could not use the out-patient department?

DR. SCHAAF: Any doctor who has hospital privileges and is permitted to do that type of work could do it in the hospital. That is so whether you do it in the bed or in the out-patient department. We are not differentiating between surgical service now rendered whether the patient is actually hospitalized or whether he comes under the out-patient department. We formerly did.

If there are no more questions, thank you for coming, and good night. (Applause)

(The meeting was concluded at 10:30 p.m.)

CIVIL DEFENSE SYMPOSIUM

Sunday Evening, May 13, 1956

The Civil Defense Symposium of The Medical Society of New Jersey convened at Haddon Hall, Atlantic City, on Sunday evening, May 13, 1956, at 8:20 p.m., Dr. R. Winfield Betts, Chairman, Special Committee on Emergency Medical Service, Civil Defense, presiding.

DR. R. WINFIELD BETTS: Good evening, Ladies and Gentlemen. The Medical Society of New Jersey welcomes you to a Civil Defense Symposium on mass casualty care. The Society has a concern that perhaps the physicians of the state might need some additional training or a changing of views or attitudes toward trauma. That is the reason for this program. Civilian medicine doesn't always show the same trends followed by the casualty care of large masses of patients.

Tonight we will have a presentation by three experts in surgery: Lt. Colonel Joseph D. Goldstein from the School of Atomic Research in the Walter Reed Medical Center; Colonel Joseph R. Shaeffer, Chief Consultant to the Surgeon General of the Army;

and Dr. William T. Fitts, who has kindly consented to take Dr. Hamilton's place on the orthopedic presentation. We will then hear a presentation of the training program of the United States Public Health Service, by General L. E. Burney; and finally we will have a panel on disaster planning.

LT. COL. JOSEPH D. GOLDSTEIN: Mass casualties—What causes them? What is the medical problem? What are you going to do about them? Nuclear weapons are probably here to stay. They may be instrumentalities of war. Let's see the way they work.

In 1905 Einstein attempted to equate energy and mass. Essentially he said there cannot be destruction of energy unless we have destruction of mass. He was dealing at that time with astro-physics. He had no idea that it might be applicable to micro-physics. We now know that it is.

We speak of a fission and a fusion reaction. Essentially in the *fission* reaction we add a particle to the basic element of any physical component which we can recognize. Say we take uranium 235 and we add a neutron to it. We come up with a fissionable reaction from which we get a fission fragment. This is a random breaking; it might go anywhere from 30 to 60 on a relevant scale—plus neutrons. These neutrons again react with more fissionable uranium 235 and we have the chain reaction.

With a *fusion* reaction, we take light elements such as hydrogen and we take another atom of deterium and we come up with again helium. This has been going on in the sun for millions of years. We mortals have now approached this reaction.

Einstein's equation states that for every mass that you put into a reaction you must have an equal mass at the end of the reaction, or energy. In both reactions, the resultant products weigh less than the inter-acting products. To over-simplify it, the resultant loss of mass manifests itself in a release of energy.

How much energy? For each atom probably very little in relation to our conventional ideas of energy. But when you have billions of these atoms reacting in one-millionth of a second, you get a release of tremendous energy amounts as in kelatons or megatons. For one kelaton of any fissionable material fission can put out 20,000 tons of TNT energy. Today we speak of megatons—millions of tons of TNT. This is a hydrogen bomb in the face of tremendous amounts of heat to make this reaction go, and therefore we have the expression thermal-nuclear reactions.

In our area of interest, what does this mean? We have a release of blast energy, thermal energy and ionizing radiations. There are two areas, the blast and the thermal. They are similar (except for the amount of energy put out) to conventional chemical explosives. Ionizing radiations are peculiar to these nuclear reactions, and this is what makes them different.

Blast energy can create casualties directly or indirectly. Directly it requires a terrific amount of over-pressure. For example, three pounds of over-pressure will demolish the average home, a little brick or wooden dwelling. It will make splinters out of an ordinary wooden dwelling. Yet it would take about a hundred pounds per square inch of over-pressure to affect the hollow viscera of the human body for lethal results. We are built so we can take quite a bit of punishment.

Will we have many of these casualties? We don't think so. In the areas in which these will occur, we will have other over-riding lethal effects, either due to thermal radiations, which create burns; or ionizing radiations which have their typical reactions such as x-ray sickness or radiation sickness. But the indirect casualties well may result in anywhere from 60 to 90 per cent of all the injured.

How do we get these created by missiles? In the destruction of a building like this, the window panes can create thousands of stabbing type of missiles. Cars, automobiles, anything can be thrown about and create a missile. You, as a human being, can be picked up and thrust through the air and act as a missile. It makes no difference whether you are hit or whether you hit. The end result, a casualty, is the same.

THERMAL REACTIONS

The thermal reaction causes the burn type of casualty. This includes air bursts, ground bursts, and sub-surface bursts.

Here is the ground surface. Here we have a blast. The blast waves go out; they travel at about a rate of one thousand feet per second, which means you can count up to five before it travels a mile. In the Nevada flats when they went off at high noon, we saw the light; it was bright. You knew that they went off. This thermal radiation is transmitted at about 180,000 miles per second.

How about the individual who is standing out here? (Indicating) If this light sees that individual, it will burn him. This light is delivered in about three-tenths of a second. You can't take much action in three-tenths of a second. However, anything between the individual and the source of light that will obscure

it—a tree with leaves, smog, snow, anything that will obscure it will protect him.

So when the light is seen, if this individual has not been seriously affected by the thermal radiation, he can take evasive action against this blast—fall into a gutter, protect himself, preferably get into a cellar, if he can. There is plenty of time if he is out far enough where he can take action.

The primary type of burn from thermal radiations will burn only what it can see. And we can see what will burn us. It will take in the infra-red and ultra-violet, but in the main and loosely speaking, it is the light that we can see if it sees us.

IONIZING RADIATION

The third factor is the ionizing radiation. This comes out with the same speed as the thermal radiation, but for this material you have to have shielding that is much thicker than you need for the burning radiations. Fifty per cent of the ionizing radiations are delivered in one second; a hundred per cent in ninety seconds. The latter fifty per cent may be purely academic if you have had enough from the first fifty per cent.

What will shield from the ionizing radiations? One-half inch of steel, four and a half inches of concrete, or six and a half inches of dirt. Thus if you are in a cellar or basement or behind a thick concrete wall you will get a measure of protection against these ionizing radiations. You will not know when you are being hit by ionizing radiations. You will find out about it a week or two later. By then, there is little we can do about it. It will run its course. We can give some supportive care, but that is as far as we can go at present.

Thus, three types of physical casualties result from this weapon. One is the missile. Another is the thermal or burn, and here I only spoke of the direct burns and not the ones due to conflagrations of fire storms; and finally the ionizing radiations.

CASUALTY INCIDENCE

We will have numbers of casualties created in a very short time period. In Korea in three years we had 140,000 casualties. In a town or city of 300,000 under proper conditions you can receive 140,000 casualties not in three years but in less than three seconds. In Hiroshima but a few hours after the detonation 10,000 casualties—and this is documented—came down and deluged the only available 600-bed hospital. These are mass casualties. That is what we are talking about and that is the sphere in which you must think.

If we selected only twenty of our seventy target areas in the United States and subjected them to effective nuclear weapon assault we would create five million hospital type casualties. At the same time we would incur a tremendous attrition of our medical potential to take care of those people.

These two factors work in opposite directions. They create an intense need for medical requirements, at the same time vitiating our medical resources. We have not enough to handle that which we must handle.

Take Washington and Baltimore. Washington is here. So therefore you are going to back up and start going in this direction towards Baltimore. But the day of the single weapon and single target is over. That was in 1945. Baltimore is a lucrative target. It has been hit. Now you start backing up and you meet, shall we say, cheek to cheek, neither one being capable of supporting the other. So this method of mass evacuation falls right then and there. You can lend very little credence to that in your planning.

The next question is shifting reserves; let's bring them into the area from somewhere else. How feasible is that? Where are you going to get your reserves? Have any of you tried to move a well organized military organization a couple of hundred miles? Let alone a civilian organization that isn't organized, and orient them into a situation.

We have right now in the United States about 206,000 physicians. And what I say for physicians applies to nurses and other allied health agencies. Let's assume 75 per cent of our medical potential is within target areas.

We have 206,000. But 56,000 of these are either old, infirm or engaged in occupations other than patient care. This brings us down to some 150,000. From these 150,000, if we assaulted 20 target areas in the United States, we would lose 37,000 doctors. At that time we would be in a state of war. And if we went to a twelve millon armed force, at three doctors per thousand individuals, not three doctors per thousand casualties—that is quite a difference—we would take out some 36,000. You would wind up here with 80,000 doctors, plus or minus. Our crystal ball isn't that good. We just try to come out with an order of magnitude of being reasonable to the approach

Now, you have some 80,000 or 90,000 doctors. You have five million casualties. What kind of casualties? Not the kind that you can turn back with a pill or an aspirin. These are hospital casualties. If you could mobilize 50,000 of these doctors and transport them to

where they would be needed—and this is a very moot question—you would come up with one doctor per every hundred seriously wounded individuals within the first 24, 48 or possibly 72 hours.

This is an extremely optimistic picture. You would probably be much more correct if you assumed either one to three hundred or higher. Interestingly enough, we can take this and work it out for a front line battalion in contact under these conditions and we come up with the same figure: one surgeon for about 200 to 300 surgical patients in the first 24 hours. Reflect on that for a moment. We can't do the job on a "business as usual" basis. We need more hands.

OPERATIONAL CONCEPTS

Is this overwhelming? Does this agitate us into a state of despair? It might. But we in the medical service choose to elect this as a stimulus, as a challenge. We think we can meet the situation with hope and faith.

Here are our operational concepts: survival care; sorting; economic utilization of medical assets; organization; pre-planning; training. For "survival care," we say: elevate first aid to sustaining type medical care. Survival care is that type of care that will be rendered by non-medical individuals or non-medically trained individuals at the time at the site of injury. In essence, it is first aid. But it is first aid geared to meet the special situation.

Under these conditions no longer is first aid a temporary type of care. It now becomes a sustaining type of care. There simply will not be doctors available during the first 96 hours to take care of these people. Every person must be his own physician during that period and carry out these survival measures or else they will not be accomplished.

STEPS TO SURVIVAL

We are going to lose lives in combat. That is the cost of war. Must we lose them needlessly because we will not face up realistically to the situation? The answer will come from your conscience.

Survival care is reduced very simply to five steps.

1. *Arrest bleeding.* How do you arrest it? Simply by a pressure bandage. If a pressure bandage will not work—and, by the way, it will work and it is preferential if given half a chance to work—but if it doesn't work, use the tourniquet. If a tourniquet is applied to the limb under these foreseeable conditions, in all probability that limb will be sacrificed by amputation. You save a life, but you spend a limb.

2. *Insure a functioning airway.* It makes no sense to put a lot of dressings on people and have them asphyxiate on the way to medical aid. For instance, a simple manipulation with the fingers into the throat to remove a loose denture or a tongue that slipped back into the throat. This can save a person's life. That's the kind of thing that we are referring to. Remember, we are dealing with non-medically trained individuals.

3. *Splints.* Use the term "immobilization" rather than "splinting" alone. Immobilization is not tantamount to traction. Train people to understand that the uncontrolled movements of these fragments of bones will destroy vessels, arteries and nerves and tissue and therefore lead to shock and probable death. When people understand this, then the reason for splinting or immobilizing a fracture prior to use takes on meaning. It becomes inescapable.

4. *Dress and bandage wounds.* Why use dressings? For pain, to stop bleeding, to maintain physiologic as well as external function during this time. These are the only reasons.

5. *Handling and movement of patients.* Bring out the concept that when you approach a patient or casualty you do not treat this wound alone. Treatment of the injured is not synonymous with treatment of the injury. Inspect the casualty. See what is wrong. Think of the priority for treatment. Is he bleeding to death or is he choking to death? This requires a little judgment. The average person is capable of this judgment if he is given the material on which he can make this judgment. And we doctors had better do that because we will not be there at the time to do it.

A word of reassurance to these individuals; some fluids by mouth if they are conscious; warmth of the blanket and proper positioning may make the difference between a live casualty or a dead body. It is as simple as that.

How are you going to train people to do this? By the exchange of ideas. Every day people are threatened with things that may affect their lives. They understand plain language. It can be couched in very plain terms.

We have not included shock in these five steps. It is questionable if the average person could recognize shock—or do anything about it. You *could* teach the public about a weak, rapid pulse, shallow respiration and a clammy skin. But they don't know what a normal pulse is; they don't know where to find it, and they don't know what normal respirations are. So let's not becloud the issue. If they use these five tangible measures correctly, they are in effect preventing shock. Preventing shock is better than arresting it.

SORTING

Our next concept, is "sorting." A fancy word for this is *triage*. The term "sorting" does not mean selecting one commodity from another. Sorting means selecting the individuals and giving them a priority for the available treatment. We have done this for a long time in military medicine. It is in two dimensions: the type and the extent of the injury. Heretofore, having a lot of capabilities, we have taken the most seriously wounded first. But under mass casualties, where you will have a tremendous disparity between what you will have to do and what you will have to do it with, you will have to save the most lives that we can under these conditions and provide the best care to those that we save. Therefore, we have to sort out these individuals not only on the type and extent of injury, but also on the prognosis. What is their probability of response to the available measures at that time and at that place?

The four classes of sorting are: minimal, immediate, delayed and expectant. In the *minimal* group we have patients who, after they have received minimal care, can take care of themselves. They can go back and become effective individuals. Among this group we will have people with 10 per cent burns over the body surface, if the face is excluded. They are the very people that today would come into your hospitals. Fractures of the minor bones and emotional disorders will fall into this group. They are going back and they are going to work. Why? We will have a compelling requirement, the like of which we have never known before, for manpower. That is why we need these minimals. At Anzio with World War II standards we returned 11 per cent of these people to duty. In civilian disasters, you people have returned forty per cent. They will need treatment at a more opportune time. The stakes are coming high now. Let me remind you; we are not laying down these terms; they are made for us. Whether we like it or not they are the rules of the game. Let's hope we never play it, but if we ever play this game, we better know what the rules are.

In the *immediate group* are patients who require resuscitative and life saving surgery. They are the ones with excessive bleeding of vessels, sucking wounds of the chest, and probably open fractures of the major bones or incomplete amputations.

In the *delayed group* we find casualties who, following just minimal resuscitative care, can be held up for 48 or 96 hours without too much additional risk. Closed fractures of the major bones and 20 to 30 per cent body surface burns will fall into this category.

In the *expectant group* are individuals so critically injured that experience alone has taught us that regardless of what we do for them their chance for survival is remote and poor. Burns of over 50 per cent of the body surface—if they were brought to the steps of the best hospital in town, would stand only a one to two chance of survival. Complicated central nervous system injuries and injuries of the chest and the multiple injuries would fall into this group.

Are they to be abandoned? No. They are to be set aside until we can get to them. When we can get to them, we treat them. We hear many say that this is just cold and ruthless. Nothing can be further from the truth. These principles have been developed by people who have searched their souls and have thought it through completely. If we can save 25 individuals here against one here, who is to say that these 25 have less of a right to live than this one? And when a physician loses his sense of compassion, he has outlived his usefulness.

Who is going to do the sorting? The best surgeon available at the time. Doesn't he do it every day? Of course, he does. How about the surgeon who opens up the abdomen, looks in, says sorry, we better close him up; this is metastatic malignancy. He is far beyond what I can do for him. He closes it. In this condition the same man will say the same thing. What is the difference? In the former case his sentence is applied six months later. Now the sentence will be executed probably in 24 to 48 hours. That is the only difference.

Does he assume supernatural powers? No. We let him have some at the time because he is the only one who can judge between the quick and the dead. But in essence he is doing that now. Therefore, the man who should do it is the surgeon who is doing it every day.

Are these classes inflexible and arbitrary? Quite the contrary, they are completely flexible. They vary with the time and the occasion and the judgment and the information that the surgeon has at that time. If he can establish criteria, then he must. We aim at the optimum care of which we are capable at the time. What we will have, some others beyond our control will dictate for us.

PERSONNEL AND FACILITIES

The third principle is the economic utilization of medical assets. We break it down roughly here: personnel, facilities and supplies.

Everyone within his own capabilities of all our allied health agencies and disciplines must be trained to do much more. They must be expanded.

This term grading and re-grading leaves much to be desired. Trained surgeons will not be strapped to one operating table. They must be in a position of supervising others with lesser skills so that they can carry out their knowledge on behalf of the greatest number at that time. Now, if we do this with all our people, and by that I mean the nurses, the veterinarians, the dentists, the medical corpsmen and all other disciplines interested in health, if we do that, then we cannot dissipate this potential on non-technical procedures. This must be done by other than non-medical people. Policing an area, security, transporting the sick, carrying litters, non-medical individuals must do this.

How are we going to get the most out of *facilities?* We will gear our facilities to meet the type of patient that we expect; the missile, the burn and ionizing radiations. In essence our well-balanced facility of today becomes a surgical facility for this special occasion. Other activities must be temporarily subdued during this time.

We will never have enough *supplies.* We never have had enough. Supplies must be expended from the outset in consonance with the priorities of which we just spoke. If you have ten units of some parenteral fluids you can't give it all to the first burn case coming in requiring ten units of fluid. You will have to think about the cases that you are going to get, based upon your information, and then give it to the greatest number that you are going to save. This doesn't mean you give the next thousand patients 10 cubic centimeters each. What you do, you do properly, but you don't undertake to do anything unless you can do it properly and it is necessary to save the life of that individual under the times.

PLANNING AND TRAINING

Many individuals will now have to assume responsibilities and do tasks under these conditions that they normally do not perform. Now we have to come out and state the minimal levels of proficiency in our planning. Once we state those proficiencies we have to provide opportunities for these people to get the planning. We've got to get rid of arbitrary legislation; we have to get rid of obsolete customs. Competence is the only basis upon which we can work if we are going to survive.

Our survival as a nation is being challenged for the first time in a long while. We are not talking now about whether you are going to replace butter with oleomargarine or substitute nylon for silk stockings. Are you going to survive as a nation? If you feel smug and comfortable, just sit back and realize that that is what we are referring to—not whether you will have the niceties of life, but whether or not you will live. So therefore all these obstructions just have to be pushed aside if we are going to face this thing realistically.

Every hospital has to be capable of taking care of five times the number of casualties that it can take care of now. We don't speak of beds anymore; we speak of capabilities. Read your local newspapers. Thirty people are injured in a train wreck and it paralyzes the medical profession of that town.

The civilian disasters we have experienced in the last ten years are peanuts compared to that about which we are speaking. But what have these disasters done? They have completely paralyzed for 24 to 48 hours the supporting medical facilities. These facilities must also gain from these experiences.

In this kind of organization there is one word that we always have to remember in all our hospitals. Without it all you have is organized chaos. The word is "Control." We in the military are very much acquainted with this term. If you have read the reports of various civilian disasters you will see the common denominator that runs through all of it is *control* and *communications.* Communications are the eyes and ears of the man who controls. This is the thing that fails: patient control and your working personnel control. Unless you have a system that can marry the casualties to your medical care, whatever you have isn't worth the paper it is written on. Control is the thing that you must have.

You can't hope to pre-stock everything that you need because chances are where you will need it you won't have it anyway. What you do is select the items that you will probably need. The people who are going to use it must be acquainted with the material they are going to use, where they can get it, and how they are going to use it.

Your plan must involve your present facilities. It must also envisage that your present facility will be blown to kingdom come; that you will work in an improvised facility. Your plan must be able to work with 50 per cent of your personnel and maybe less of the materiel. You must work with that which you have.

Is that complete despair? No. It has been done before. We can do it again. Many of the things that we speak of now are refinements. We can cut them out and we can get away with it. You will see how many of these refinements were pushed aside in Korea. Yet in Korea only 2½ per cent of all the casualties admitted into that type of medical chain died. This was the best record world-wide.

We have reduced it from 22½ per cent in the last hundred years—based upon very simple procedures.

SUMMARY

Nuclear weapons are an established fact. They are being stored in our military arsenals on both sides. If used, we must face up to a disparity between our medical resources and the casualties. This is important if we intend to recuperate as a nation. We in the medical service of the Armed Forces have seen this disparity. We recognize it; we accept it. It is a challenge. We feel confidently that we can for our part meet with faith and resolve that disparity and bring it within manageable proportions. With equal faith we feel that you, when you are in possession of the facts, will do your part, as you historically always have done. We in concert then can contribute the entire medical effort for insurance of our national community against the one thing that is worse than war; and that is defeat.

(Applause)

DR. BETTS: Each time I listen to one of my brethren in the military service I get a little bit more optimistic about the situation. When I talk to my brethren in civil medicine I get a little bit more discouraged because they all say it can't happen here, and we can't do anything about it.

COL. JOSEPH R. SHAEFFER: I have listened enthusiastically to Colonel Goldstein's remarks. He has very honestly outlined to you the problem involved in disaster management. I wish the auditorium here were better filled. The mere fact that there are so many empty seats here is expressive of the almost complete disinterest in this subject today in the United States of America—the current complacency that exists in the country regarding the probabilities of what might happen to us as a nation; the smug complacency that exists among our people, that because we have survived successfully as a nation grants us immunity against the probabilities that it can't happen.

I would remind you of public press notices that we could defeat the Japanese Navy on any Wednesday afternoon, given the opportunity, and that we did wake up to the simple fact on a Sunday afternoon that the Fleet was at the bottom of the bay. There is an appalling disinterest and apathy regarding the entire subject of mass disaster. Yet many of the guiding influences of medicine today are those who have, of necessity been at one time or another in the Armed Forces and are completely familiar with the problems involved under war conditions.

There are cities by the name of Nagasaki and Hiroshima. In split seconds, hundreds of their people were slaughtered and an equal number or more were left physically incapacitated and in need of professional care. No good, sound, solid professional care occurred for five days. That is a long time to hang from the apple tree.

The devices do exist, the incidents did occur, and I also say that historians must of necessity always write that the United States did it first. Right or wrong, that can never be erased.

I would also remind you that we have been plagued with disasters—natural, fires, floods, windstorms of all kinds and severity, inflicted upon our communities. Studies of the management of the problem of disasters under these conditions have shown that control in most areas has been anything but satisfactory. Granted that much good was done and that from that chaotic state, proper leadership finally developed.

But somehow or other, as we referred to Nagasaki and Hiroshima, civilian disasters and military experience, we still don't get the concept. It is not in terms of fifty casualties. Come on to the fire, the flood where you have a few hundred, or something a little more major in terms of, say, a thousand, fifteen hundred people in need of care. But the device we are talking about can create 150,000 dead and 150,000 surviving people in need of care with practically no medical facilities, resources, supplies, skills of any moment available to care for them.

Now, what are we trying to do? As Colonel Goldstein points out to you, the problem is one of what are you going to do for yourself if you are injured under these conditions. There are no lights, there is no heat, there is no water, there is no telephone, there is no avenue for running—it's rubble. Even if you ran, you don't know where you are going because you don't know where the motel is you are going to sleep in. You don't know where you are going to feed this family or you haven't seen your family, and you don't know that you are running into radiation fall-out of 5,000-air that is just as lethal as the bomb over here that incinerated you.

This country of ours has survived three wars in our time: World War I, World War II and World War III, which was Korea. I don't think historians five hundred years from now are going to talk about I, II, III and IV. They are going to talk about the continuing one hundred years' war. And don't tell me the Korean incident was a police action because I think there are many families in the United

States that are minus a son because of it. It was a war.

The problem in simple definition resolves itself into how are you going to take care of the injury to yourself and those about you who might survive any catastrophe. What are the basic principles of all surgery which will survive all time? Regardless of the progress of scientific medicine and surgery, though we may find the answer to thyroid disease, ulcer, cancer, and we probably will, injury sudden in its onset is unpredictable and will always happen. Basically it is the problem that sustains in all time from there on out, surgery. Surgery is the handmaid of medicine and what we do objectively is in terms of experience of what we may do if the life does survive. It is wishful thinking that a day will arrive when we know the answer to many of the problems that we handle surgically. The treatment of cancer today is admittedly by the knife, but some day we will beat it. I think if we devoted the billions of dollars to the scientific investigation of cancer, that we have for the atomic bomb, we'd probably have the answer now. That is my personal opinion.

How do you take care of yourself? Do you know today how to bandage the wound, splint the area, remove the individual from danger? Can you sensibly save this life or protect it against further injury? And as has been pointed out to you by Colonel Goldstein, our problem is one at the moment of saving the greatest number of lives to save the nation in the event of a new war in which these atomic devices are used. It's just that simple.

A gentleman in the back of the room told me tonight that it's just so terrible, it just can't happen. If it happens, it is just too bad and we are done. Yet many of us feel that this is not good thinking. We don't think it is sound, solid American citizenship and we don't think it is sound, solid American medicine, because the best offense, civilian or military, is still the defense. If we look at the problem realistically we can come up with a reasonable solution, if not an ideal one. But this answer is not in terms of business as usual, conventional application of principles to everyday life in the field of medicine.

That it *may* not happen in Atlantic City, I concede. But that it *could* happen, yes. Many a town has thought it was immune to disaster, suddenly to find itself in the throes of tragedy. Read the documented, substantiated evidence of the breakdown in all planning and patterning for its management, particularly in terms of its professional care, and that is my area of discussion. How do you manage injuries under these conditions?

I want to show you selected slides of the professional problems involved in the management of wounds under stress conditions. Remember you will not have your operating suite of today with your facilities in terms of blood, substitutes, resuscitating measures of all kinds. You will not have the nurse and other attendants. How about wound management then? I'm going to show you civilian and military slides alike. This was from the Worcester flood disaster that was very minimal in character. There were 1500 injuries. They did a good job. But they had many breakdowns. Do you see that man with the shirt off his back? It was wind that blew the shirt off. He was not dragged through the streets at all. This is dirt. All these wounds under these conditions, fire, flood or otherwise, are contaminated and medically speaking they are dirty. We must treat them as such.

The next slide is the contrast from Korea. Something exploded in the boy's face. He did not become blind. All these pictures are those of living individuals as of today.

Here is a man who had an injury of the scalp in Flint, Michigan. It looks partly compounded. It's not. It could be cleansed; it could be sutured back under proper conditions.

Under these conditions with collapsing buildings, you are going to have many head injuries. They are low in priority for care, very low, because it takes a neurosurgeon, or those with experience, hours of time to explore and treat properly the case. After you've gotten all through treatment, proper though it may be, you are up against the problem of post-operative management which, under these conditions, will very probably be in the hands of non-skilled, non-professional individuals at remote places, and by itinerant professional supervision.

This shows you the neck injury of the individual that might be hurt. This could be serious; it could be simple. The problem here is one of dressing to prevent further contamination. If there happens to be soap and water, cleanliness. Maybe he needs a tracheotomy. All injuries around the jaw, the face, the neck region, be they burn or mechanical, should raise the question of early tracheotomy.

In your teamwork in the establishment of organization *now* and not later, the senior surgeon with experience in the handling of wounds under field or mass conditions should be he who stands and guides and directs what will and will not be done. He will establish priority for care. We, at this time, endow him intentionally with a God-like quality as he stands there and says: this individual is in need of blood which we don't have. This in-

dividual must wait his turn; there is nothing life saving that we can do. This individual must be operated on immediately, if we have the surgeon available, if his life is going to be saved. He will not be lost in the operating room during surgery because surgeons will be high in priority at this time and all doctors, regardless of past training and experience, under mass casualty conditions of hundreds of thousands of casualties suddenly become surgeons because there is no room for any other specialty.

Here is the simple wound of the extremity so familiar to all. Do you think these are very simple of management under disaster conditions? This patient received a dressing. Let me show you what happens when a small bit of lead from a .22 caliber bullet passes through the soft tissue of an extremity. This lucid area of cavitation shows you the tremendous amount of destruction that occurs from a .22 caliber bullet when it went through the soft tissue or flesh of the arm or leg. This shows you, if you let your imagination run, into the destruction that occurs to muscles, fascia, blood vessels and nerves. This is tremendous. It brings up the problem of debridement or cleansing of wounds surgically. This is a problem that you cannot discuss logically from the platform nor write about in books. You must take the doctor to the operating room, if he is a dermatologist or an obstetrician or a public health officer, and show him how you will do this operation if it is to be effective.

Here is an arm from Flint, Michigan. Something went through the air and through the arm, possibly a segment of a bathtub. It shaved off part of the arm. It is dirty. Under ideal conditions we can surgically cleanse this wound by debridement. We get this result in four or five days, a very clean wound, very healthy looking wound which can be skin grafted or closed otherwise. We get an excellent result.

The first slide will tell you that you will bandage the arm if you have bandages available and the arm will go in a sling and he will return to some effective activity in terms of welfare for others or rescue procedures or putting out fires in the environment, because he still has another arm, two legs and a head. That is an assumption, but this is not life saving. If you are surrounded with a hundred thousand casualties and if you have skills to do what you know you should do, sacrifices must be made within reason. This is a concept that the profession must grasp if our teaching and training program of the nation is going to exist, because we up-grade those with partial training, those with partial experience to do the job. It will not do to say this is entirely professional and that the surgeon should take him to the operating room and spend two or three hours managing this problem when you know morally that under these conditions you could have been taking care of 75 other casualties with an equal expectancy of survival.

Shall we continue to teach the civilian population the treatment of hemorrhage is one of the application of tourniquet? Visualize now, if this is true under these conditions, that they will be applying tourniquets to arms and legs promiscuously including the neck. That isn't going to save lives. Yet contrarily I say to you that this arm shattered of bone, blood vessels and nerves must be amputated under these conditions; that there will be no opportunity for repeated surgery and combating infection with the antibiotics that may or may not exist, or the resuturing of nerves or blood vessels. This limb can be amputated and the person restored to effectivity in a brief period of time. That is what we are after; to return to the effective survival of the nation of the maximum number of individuals regardless of the responsibilities.

Now, this is one of the last few I am going to show you because it is so typical of what could happen to an injured leg. Under these conditions the properly applied bandage is significant and effective in returning the patient to some form of working activity at the time on the scene of the disaster.

I call attention to this fact: I have said nothing, I imply nothing, I will never say anything that says to the surgeon that if he has his skills, his facilities and resources available and his work load is accomplished that he doesn't have a thousand back of him for whose lives he is responsible, that he will not do other than what he knows to be best and follow out the principles that have been established for the management of traumatic injuries.

Now, this happens to be a case from Korea. Let me show you what was necessary properly to debride this leg under conditions of warfare. And I don't think that the dermatologist or the cardiologist or the health officer in the room is going to undertake this kind of surgery under a tree in a field, in rubble, in fire storms about you, in these first 48, 72, 96 hours of time. This converts the individual definitely to medical channels.

The essential part of the problem is one of first understanding the basic principles of the management of the traumatically injured individual today, from the simple fracture to the compounded. I would like to know, in

spite of the time honored principle of splinting fractures, regardless of the circumstances, the number of cases that come into your hospitals here in Atlantic City un-splinted, yet we know and the Boy Scout knows and those who went to Red Cross class know that you were taught initially how to splint. Under these conditions in splinting fractures, the problem is one not to anticipate the best. I see no ambulance, I see you on your own, and I see broken arms and legs, and what are you going to do? You are only going to know how to do through pre-study in evaluation with improvisation and substitution for ideal mechanisms.

Here is a wound of the chest. This patient can be saved if the wound is closed by a dressing, preferably wet. It will be wet from the blood coming from the wound. If we close it, the victim has a chance of survival and treatment of his chest later on. If it is not closed, he will die. There are other cases that should be operated on and have a thoracotomy. Under the conditions that you may visualize by what we have already learned from past experience, you may not even have an anesthetist available. Probably some of you haven't thought about that up to this moment in my discussion.

We come to the abdominal wound. I pass over it hurriedly because it is low in priority for care. When you explore an abdomen it may take a half hour, it may take 3½ hours actually to handle the damage done within, because the simple wound of the surface belies the extent of injury beneath. There may be injury to many viscera. It is a long, complicated procedure probably and you must have ample quantities of supporting fluids, antibiotics and then you must have postoperative care. I say nothing about nurses. I don't think you are going to have the nurses in ample quantities under these conditions. This victim must be evacuated somehow or other from your facility to keep it from becoming paralyzed, so you could do the maximum good for the greatest number.

Here is a fracture. The answer to the injured extremity right now is a splint and bandage in every home in the United States of America, with the simple know-how on its application or its substitute.

The injured hand is really a significant injury under these conditions. I want to point out the treatment under these conditions, treatment which is not very well carried out today even by those who know better. One prime element is control of the bleeding through compression bandage and splinting in the position of function for possible utilization some other day, evacuation to those some day who can and do know how properly to restore this hand to some sort of function. Regardless of our thinking, any prosthetic device that has been invented to substitute for a hand is poorer than what he might get out of this. The hand is going to be important. No one should undertake surgery of the hand without understanding the basic principles even under ideal conditions because this is the tool, the brain, the livelihood of the individual and possibly his family.

Here is a burn. Under atomic and thermonuclear war, we may have 65 per cent of the causalties burned. It will not do for the profession to say: I'm a pediatrician; I know nothing about burns. You've got burns and wounds and radiation illness. It will be up to you to handle burns. This is a major problem in terms of handling the wounds.

It is my opinion about burns that those probably of, say, 10 or 15 per cent will be immediately returned to some form of effective activity at the scene at the time, for which there will be much demand.

Those between 15 per cent and possibly 40 will be in need of some form of professional care sooner or later—fluids and bandaging. I don't see the quantity of bandages necessary to take care of a hundred thousand burns. And when we talk about stock-piling gauze and bandages, I don't know the skills available to properly apply. I don't know as a matter of fact that they are going to be available in the 72-hour period of time in sufficient quantity to take care of the greatest number. You cannot teach anyone simply how to bandage burns about the neck and the shoulder region. It is not simple. How about exposure treatment? If it is 32 degrees above zero and you've got no heat I don't see how that will help.

Something has got to be resolved in the nation today on how better to manage the burn problem in terms of thousands of casualties. There *will* be thousands in the event of a new war. I don't think it safe to say it isn't going to involve Atlantic City. The burn problem is tremendous. Those with over 40 per cent body surface burned under these conditions are probably going to die.

Here is the operating room of a mobile surgical hospital in Korea. To many of you in the room who have not had military experience, it doesn't look clean; it doesn't look healthy. That's true. You see tin cans and wires about the place and all kinds of substitutions and gadgets. You see caps and masks, in some instances you see bare arms and without gowns, yet under these conditions, it was possible for us to lower the mortality rate in military medicine lower than it has ever been

before in the whole military history of the world: we lowered it to 2½ per cent.

Think in terms of atomic warfare or thermanuclear warfare involving the nation, in which your country has told you it is planning on 70 target cities today that might be struck simultaneously with the creation of as as many as eight to twelve *million,* not thousand, individuals who are hurt and in need of professional care of some kind, and that is our problem.

Go back and read what happened at our civilian disasters in Worcester, in Flint, in Waco, in Texas City, Vicksburg, Winfield, Kansas, the train wreck at Los Angeles. Look at the Monday morning quarterbacking. We can't be too proud in spite of the fact even today we think we are organized. We think we have a team established and set up to take care of the disaster should it strike here: a tidal wave in Atlantic City. I'm not so sure.

This nation, I think, has a right to look to its professional organizations for guidance in what is necessary for planning and training in terms of not only handling the simple injury to the individual, but, in addition to that, the disaster in terms of the train, the plane, the flood, the fire. And then if it must be our fate —and let me join the group that prays that it never happens—if we do get into a new war and we are struck with these devices that are talked about in the newspapers, that we have some concept of what we will do, that we will have a plan at the local level that is the best possible under the circumstances to fabricate so that we can live up to our reputation that we have inherited not only as a profession but as a nation.

Thank you very much. (Applause)

DR. BETTS: Dr. William T. Fitts, Associate Professor of Surgery at the University of Pennsylvania, is going to talk to us on emergency management of fractures.

DR. WILLIAM T. FITTS: Dr. Betts, Ladies and Gentlemen: I am pinch-hitting for a really great speaker, Dr. Oscar Hamilton of St. Louis. Our subject is the emergency treatment of fractures. We are going to expect a lot of fractures under disaster conditions. A lot can be done for fractures in getting people back to work, back to duty by untrained personnel. The ophthalmologist, the dermatologist and other doctors who are not used to treating fractures are going to be the ones who will have to handle these patients when they are first seen.

AN ADEQUATE AIRWAY

The saving of life comes first. Treat impending asphyxia, hemorrhage, shock and other life endangering conditions before treating the fracture. Because x-rays show fractures and don't show soft tissue injuries, and because fractures cause deformities, we are likely to treat the x-ray and not treat the patient. Treat life endangering conditions *before* treating fractures. Perhaps the first priority is to get adequate airway. Don't stop the bleeding before you have an adequate airway. If you wait to stop the bleeding, you will have had the patient asphyxiated by that time, so that is Number 1.

OTHER PRIORITIES

Number 2: if you have a sucking wound of the thorax, close it. It won't be hard to close with a compression bandage.

Number 3: stop hemorrhage. Usually, this can be done by compression, by the layman as well as by the physician; put on a bandage and pressure.

A tourniquet is almost never needed. If it is needed do not loosen it every twenty minutes. If you loosen it every twenty minutes, the victim may bleed to death. If a tourniquet has to be applied in the first place, remove that tourniquet only when the patient is in the operating room and you can have plenty of blood available.

Fourth, treat shock by whole blood transfusion.

Fifth, continue observation for increasing intra-cranial pressure.

Sixth: splinting or immobilization of fractures.

EMERGENCY SPLINTING

Emergency splinting of fractures is easy. You don't have to have much training to immobilize most fractures adequately. In fractures of the upper extremity, all you need to do is bind the upper extremity to the body. Put the elbow at a right angle and use gauze or anything, even the shirt-tail of the patient, for a splint at a right angle. Anything that you can bind the arm to the body with will effect perfectly adequate splinting for the upper extremity.

You won't have splints available under emergency conditions. You don't need splints for the upper extremity. The Murray or the half-rank arm splint was found to be totally inadequate in World War I.

You will probably have boards or magazines available for splinting wrists or for splinting elbows.

The standard splinting for the lower extremity is traction-splinting utilizing a Thomas or a half-rank splint. Traction is obtained by

means of a hitch around the foot. Improvised splinting (if the Thomas splint is not available) is obtained by board splints.

For fractures of the lower two-thirds of the leg and the ankle the ideal improvised emergency splinting consists of two or three padded board splints which extend from the mid-thigh to below the foot.

For suspected or proved injuries of the cervical spine, the patient should be transported face up on a hard surface. Sand bags or other heavy material are placed on each side of the neck. Flexion of the neck must be avoided.

For the dorsal and lumbar spine, in suspected fractures of this area, the patient should be transported on a hard surface. A door removed from its hinges provides an excellent improvised stretcher, either face up with a small roll in the small of the back, or face downward. Flexion of the spine must be avoided at all costs.

Abduction splints are cumbersome and ineffective. They make the patient difficult to transport.

LEAVE WOUNDS OPEN

Nothing is as important in prevention of a poor result in an open fracture as a good debridement. Once debridement is done, leave the wound open. This is something that has been re-learned in each war, re-learned in Korea. Teach all concerned to do a good debridement and to *leave the wounds open* once they have done it. You cannot get by with limited debridement. You must *not* close wounds. It can't be done safely under mass casualty conditions. It was not done at Worcester. Wounds that were closed, broke down. They took a long time to heal. Leave the wounds open.

DEFINITIVE TREATMENT

There are only five ways that you can treat a fracture. The most common is to reduce it by a close manipulation and immobilize it by splint or cast. This will be the way that will be best used under disaster conditions.

The second way is by traction, usually by skeletal traction using a wire through the lower extremity, the distal femur or the tibial tubercle; or the upper extremity through the olecranon process. This requires special equipment. It requires keeping the patient in bed; it requires a lot of nursing care; it certainly will not be a good way to treat fractures under disaster conditions.

The third method is internal fixation. Most of these fractures are going to be "open" under disaster conditions. Some authorities say that it is sinful to treat an open fracture early primarily by using an internal fixation device, like an intra-medullary nail. On the other hand, intra-medullary nailing at the time of an operation, will not usually add too much time. If intra-medullary nails are stockpiled or available, this may be a good method to use under disaster conditions. Some surgeons say that internal fixation is sinful because of the danger of infection. But if you use it, the patient will be able to take care of himself soon. He will be able to walk in a few days. If the result is a good one, the patient can be transported easily. So I say that in certain instances we must not discard this method of internal fixation for fractures of the long bones under conditions of warfare or under disaster conditions.

The external skeletal fixation, method Number 4, is really useful for fractures of the tibial shaft in which you can use pins, one above and one below the fracture site and immobilize both pins in the fracture site with a plaster cast.

Number 5 is judicious neglect. Very few "disaster" fractures will come under this method of treatment. Those which respond to judicious neglect are usually impacted fractures; for example, the fracture of the neck of the humerus. These fractures will not be common under disaster conditions. So most of the fractures that we see will have to be treated with splints or casts.

Plaster casts should be bivalved to prevent damage to the circulation from swelling and ischemia. We ought to be able, in certain instances, to use internal fixation devices if we can take enough time to treat this open fracture of an extremity at all.

BURNS OVER FRACTURES

It is not easy to treat a burn that is covered with plaster. Plaster applied over a burn and a fracture may rub the skin, cause breakdown of the skin and infection. I don't think this would be a good method of treatment. We researched this in dogs. We did devise a method of getting similar fractures in a dog's foreleg. We produced identical burns on each side by immersing the foreleg in a water bath at 90 degrees centigrade for ten seconds. Exactly identical on the two sides. On one side we treated the fracture as a veterinarian surgeon would treat it, by a wire ladder splint and a plaster cast. On the other side the burn was left completely open. We stabilized the radius by insertion of an intra-medullary nail through the burn wound. If you stabilize the radius, that stabilizes the foreleg. The bones then go on and heal. You don't have to stabilize in the

dog's foreleg more than the radius to get stability of the foreleg. Here is a picture of a dog able to walk on the leg. The dog's left leg has the radius in and the dog is able to bear weight on that from the very beginning, without any pain. The other side is treated with ladder splints and circular plaster.

In general, both sides would go on to heal satisfactorily; that is, the bones would heal satisfactorily in about half of the instances. Here you see such an example. You see union of the radius treated by the wire splint on your left and also a good union of the radius treated by the intra-medullary nail on your right. So about half of the fractures went on to satisfactory union.

On the other hand, one-half of the fractures treated by the wire ladder splints and the plaster cast became severely infected. The whole foreleg broke down. Union did not occur. In a number of these dogs, spreading infection developed which caused the death of the animal. This did not occur in many of the 30 dogs who had the intra-medullary nail inserted and a stable foreleg effected. In other words, we felt that stability, even if it meant operation through an open burn wound was worth it.

It is hard to carry over this concept into the human because it is not quite fair to compare the plaster method of treatment in a dog's foreleg with plaster in a human. But this points out the great importance of stabilizing fractures early if you have a burn wound or if you have an open wound in an open fracture. By almost any other method, except internal fixation for a fracture of the long bone, you are going to have constant motion of the fracture site and therefore breakdown of the wound or a tendency for breakdown of the wound and for infection.

SUMMARY

Fractures are going to be frequent under disaster conditions. All physicians, no matter what their specialties, are going to have to treat these patients or direct their treatment by non-professional personnel. If we treat them, we should remember the priority of treatment of the injured person. Emergency splinting of fractures is easy. Nothing is more important in an open fracture than a good debridement. Always leave the wound open. Don't try to close it under emergency conditions. An intra-medullary nail can be put in in a short period of time and may even under disaster conditions, if we are operating on open fractures, be worthwhile. (Applause)

DR. BETTS: Our next speaker is General L. E. Burney, Assistant Surgeon General of the United States Public Health Service. Dr. Burney is going to tell us something about the United States Public Health Service's plan for training.

DR. L. E. BURNEY: Thank you, Dr. Betts.

I do appreciate this opportunity to participate with The Medical Society of New Jersey. If more state medical societies had more people as interested in civil defense as you doctors are, we would be a little further along, as Colonel Shaeffer mentioned.

The complacency that Colonel Shaeffer so vividly described extends to the public health profession. It is like the little boy who received a pin-cushion from his Aunt Emma for graduation. When his mother insisted that he thank her, he wrote a note saying: "Dear Aunt Emma: I always wanted a pin-cushion, but not very much." So we are about in the same position. We have always wanted to do something in civil defense, but not very much. I think that applies to the public as well as to the various professional groups.

The only way we can have any interest in the public health aspects of chemical, radiologic and biologic warfare is to include in our training these aspects of the civil defense as a part of the existing activities of a state or local health department. If you can train people or improve their technics in laboratories as a part of biologic warfare, which will assist them in carrying out their routine responsibilities as laboratory people, then they are interested. If you can take some engineers and physicians and give them some training in radiologic help, which is not too dissimilar from the radiologic hazards of atomic warfare, then they are interested; and the same way with chemical warfare.

What are the objectives of the program and the working relationships of the Public Health Service and state and local health departments? The initial objective is to provide civil defense training to key state and local public health operating personnel, who are responsible for organizational planning, and to State trainers. These, in turn, with minimal Public Health Service assistance in the form of staff and training aids, will conduct similar training at state and local levels for the many public health workers and volunteers who must be made informed members of the civil defense health and medical team. To date, a general course, "Public Health in Civil Defense," has been conducted in 13 states at the request of their state health officers, with more than 500 professional personnel in attendance. In addition, several specialized civil defense training

courses have been given as will be noted. This course is designed to present to the professional health workers, the physician, the nurse, the engineer, the sanitarian, the laboratory scientist, and other professional personnel, the public health problems posed by the employment of special weapons and by mass evacuation. I refer to the strategic mass evacuation of target areas.

The topics covered include: planning assumptions of FCDA*; national, state and local responsibilities; public health role in the state civil defense organization; and health problems of modern war. We include the implications, nature, hazard, detection, identification, fallout, protective measures, and decontamination. We study such related health problems as water sanitation, milk and food sanitation, wastes, vector control, control of natural epidemics, and emotional aspects of civil defense. We also have specialized training courses developed by the Public Health Service. Increasing emphasis will be given to courses of this kind as the need for the general orientation course is filled. To date, about 500 public health workers have participated in these specialized training courses. Other courses include sanitary engineering practices in civil disaster; civil defense for waterworks personnel; role of the public health laboratory in civil defense; and epidemiology in national disasters.

Objectives of the courses are: (1) to present to state health department laboratory personnel general information on modern warfare pertinent to the activities and reponsibilities of a public health laboratory in the event of attack; (2) to stimulate the state health department laboratory directors to initiate organization of their own laboratories to provide for maximum effectiveness in event of a civil defense disaster; and (3) to keep state health department laboratories currently informed of the technical advances in rapid identification of the biologic warfare agents and certain defensive measures.

Two courses for laboratory directors have been given in Georgia by our Communicable Disease Center. Emphasis is placed on the first two objectives. Two courses for key technical personnel from state health department laboratories will be held in June 1956. These courses highlight the technical aspects of identification of potential bacteriologic warfare agents.

Our Communicable Disease Center Training Branch will soon have ready specialized courses for health officers and public health nurses.

Certain civil defense research investigations have been undertaken by the Public Health Service. These studies deal largely with the public health problems created by the use of special weapons. This research is designed further to implement the training program. One project is concerned with the rapid identification of biologic warfare agents. In one approach, dried smears of bacterial cells are subjected to infrared spectrophotometry, and characteristic reproducible spectra are obtained. The spectral data can be transferred to punch cards and identification readily established by matching unknowns with knowns. The entire process of detection, isolation, and identification can take less than thirty hours, depending on the incubation time required.

The second method showing great promise for rapid identification of bacteriologic warfare agents is the use of fluorescein-tagged antibodies. High-titered antiserums specific for selected pathogenic organisms are developed in laboratory animals. The antiserums are then associated by chemical means with a fluorescent compound. When homologous organisms and fluorescein-tagged antibodies are combined, the organisms will fluoresce under ultraviolet light. Here is a slide showing results obtained by this technic. Both sides of the slide are photographs of the same microscopic field of an impression smear made from the spleen of a mouse infected with a pathogenic bacterium. The preparation had been treated with a fluorescein-tagged antiglobulin specific for the bacterium on the smear. The left half illustrates the smear as seen in a dark-field preparation using an ordinary light source. The right half shows the same preparation with an ultraviolet light source and illustrates the clear-cut differentiation of the specific organism.

Training is not too difficult when we include it as a part of the on-going activities of the state and local health department. We do get a little disturbed at the complacency at times, but then we have the same complacency in our own organization. The hard task, which most physicians do not like to do, is sitting down and doing some organizational *planning*, whether it is mass casualty care or whether it is chemical warfare or biologic warfare. Without this basic organizational planning and the integration of the medical aspects of civil defense with those of the other areas of civil defense, we will certainly lose regardless of the number of facilities and the number of personnel.

*Federal Civil Defense Administration.

DISASTER PLANNING IN NEW JERSEY

This panel discussion was moderated by Elton W. Lance, M.D., past-president of The Medical Society of New Jersey. The principal guest panelist was Mr. Thomas S. Dignan, Acting Director of Disaster Control in the New Jersey State Department of Defense. The members of our State Society's Committee on Emergency Medical Services acted as the primary panelists. These included Dr. R. W. Betts, Dr. Andrew C. Ruoff, Dr. G. Albin Liva and Dr. David B. Allman.

DR. LANCE: Ladies and Gentlemen, this is the last and final section of this program. We have here the Committee on Civil Defense of The Medical Society of New Jersey: Dr. Winfield Betts is Chairman of that Committee. Here is Dr. David Allman; then Dr. Albin Liva, and Dr. Andrew Ruoff.

Our guest this evening, whom I am very happy and proud to present to you and whom I have come to know over the past year, is Mr. Thomas Dignan who is the Acting Director of Civil Defense in the State of New Jersey.

Purpose of this is to bring out, by questions from the Panel to Mr. Dignan, certain aspects of civil defense as it applies to the medical profession and what the medical profession can do.

DR. BETTS: Mr. Dignan, we would like to know how many physicians comprise your staff in the State office.

MR. DIGNAN: Well, our staff, Dr. Betts, consists of the Department of Health of the State of New Jersey, to start out with. They have been given the responsibility under our civil defense law and civil defense plan, by an order from the Governor, that they will be our staff. Now, we do have one or two liaison officials who work with us in connection with the Department of Health. In addition to that, of course, we have your Society and the Public Health Service and all of those volunteers who are really members of our staff, when you come right down to it, because they are the ones who do the work.

DR. BETTS: How many work full time on this job?

MR. DIGNAN: Well, I would say just as a liaison, one.

DR. BETTS: That medical person works full time on civil defense medical affairs?

MR. DIGNAN: That is correct; he serves as a contact between the Division of Civil Defense and the Department of Health.

DR. BETTS: Now, this to me should be quite a gigantic task. Do you think that is a sufficient number of personnel to work, just one person?

MR. DIGNAN: Of course not.

DR. ALLMAN: Have you tried to get any additional help?

MR. DIGNAN: Yes, we have. In fact, for the last two years I have requested and received a budget amounting to about $21,000 per year for salaries of an administrator, assistant administrator and the necessary clerical personnel. Unfortunately, we have not been able to get anyone.

DR. ALLMAN: Is there anything that we can do to help you get them?

MR. DIGNAN: I don't think it is necessary to have a doctor for the kind of a job that we need. We need an administrator, someone who can work out plans, come talk to you and talk to the other doctors in the state, through municipalities and towns, present plans and ask your assistance. I don't think it is a need for teaching, in the sense of teaching you what to do in case of disaster. Unfortunately, we have not been able to find anyone.

DR. BETTS: Why not? Certainly in New Jersey there's got to be somebody who could fill that job.

MR. DIGNAN: If the Medical Society here could recommend somebody, I will be very delighted to take him on. One of the reasons for our problem is salary. The salary is $8500 a year. That it not sufficient for a doctor. It is also difficult to get someone to work in civil defense. This is still looked on as a "temporary" department of government, which is not true. If we could have that person enrolled as a member of the Department of Health and perhaps stayed in the Department for whatever length of time it was and then wanted to move on, it would help us in finding someone.

DR. LIVA: In what specific way can The Medical Society of New Jersey assist you in obtaining the help you need?

MR. DIGNAN: You find someone you can recommend, and if both Dr. Bergsma and I can approve that person, we'll take him on.

DR. RUOFF: Who pays him?

MR. DIGNAN: The State of New Jersey.

DR. RUOFF: Department of Health?

MR. DIGNAN: No; Division of Civil Defense. There are funds available, and there will be next year.

DR. BETTS: Well, you say if Dr. Bergsma and you approve him. Do you say he doesn't have to be a physician. A lay person would do for this job?

MR. DIGNAN: I would think so. I would think it would be more in the field of an administrator than it would be necessarily in the field of direct medicine. Someone who had a background, of course, and understood the program.

DR. LANCE: Are you talking now about an

individual who might act as a coordinator or, if you wish, sort of a deputy director? Is that what you are interested in?

MR. DIGNAN: That's right.

DR. LANCE: He might perhaps be called say, a medical administrator. Or aren't you confining it to medicine? Do you want it for the over-all picture of civil defense? Is that correct?

MR. DIGNAN: No, sir. I want it for the medical program. But the medical program includes supplies; it includes hospital plans; it includes a lot of things that are not necessarily the direct responsibility of doctors. My thought would be perhaps a man who had decided to retire but didn't want to garden or play golf, one who still wanted to keep an interest in medicine and would like to offer his services. And perhaps he would be a physician.

DR. LANCE: Let's establish the fact, that the first need that you feel is for a deputy director. We'll pass that; we will accept that as one of the needs.

DR. BETTS: I'm interested in finding out how much medical equipment we have stockpiled in the state.

DR. LANCE: Mr. Dignan can answer any question which has no confidential or secret connotation.

MR. DIGNAN: We don't have any secrets, Doctor. I can answer you that, Dr. Betts. We have purchased on the state level and owned by the Division 400 first aid medical posts. Each one cost about $3,000. They are stored in some 30 locations in units of five throughout the state. These medical posts consist of 50 lighter cots, some surgical instruments, the necessary bandages, some antibiotics, some drugs and so on. I won't go into all the details. They are supposed to be able to take care of, on a first aid basis, about 500 casualties each. Those are state owned. In addition to that, the municipalities have purchased about the same number and they store those locally.

On top of that there is a location in the state that has forty million dollars' worth of medical supplies running from 200-bed mobile hospitals to surgical instruments, drugs and everything. I may draw on those medical supplies, without asking anyone, up to ten per cent. After that ten per cent, then I have to get permission from the federal Civil Defense Administration.

DR. BETTS: You have medical supplies then for 800 first aid medical posts.

MR. DIGNAN: Four hundred owned by the municipalities and purchased by the municipalities under a matching fund program where the federal government paid 50 per cent, the municipalities paid 50 per cent; and 400 owned by the state where the federal government paid 50 per cent and the state paid 50 per cent.

DR. BETTS: Total supplies for 800. Let's be frank. How many first aid medical posts do you think could be manned tonight if a whistle blew, fully staffed with the complement of first aid personnel? How many could we actually put in the field if we had to send them to a sister state or somewhere in New Jersey?

MR. DIGNAN: We wouldn't send these to a sister state. That's the reason for the federal government stockpiling in various locations. The one in New Jersey is only one of a number. The Mechanicsburg Hospital has about the same amount of stockpiled federal supplies. Ellenville, New York has about the same amount. That's for regional use, area use. We wouldn't send our state or municipally owned supplies to another state.

If you are talking about personnel, you know just as much about that as I do. How many doctors are there in the state? How many nurses? How many people trained in first aid, who could be assistants?

DR. BETTS: How many have actually been organized so that if the whistle blew you could pull them out and say: here is a first aid medical post complete with personnel?

MR. DIGNAN: I cannot answer that. I'm quite sure that there are more than you think.

DR. BETTS: I gave a rough estimate of two or three complete first aid posts that could be manned. That's with the full complement of personnel.

MR. DIGNAN: Oh, no. In our natural disasters, floods and hurricanes, your profession certainly has come in and the nurses have come in and so have skilled first aid people. Maybe they are not organized. We'll say that we have eight members of a team in each locality. Certainly every member of your profession when they are called upon will come in and operate one of those first aid posts.

DR. BETTS: But the full complement of each first aid post consists of two doctors, six nurses, 150 stretcher bearers. We are supposed to have one of them for each 5,000 in New Jersey. Do you think that we have anywhere near that number of first aid posts mobilized or manned or capable of being manned in the state?

MR. DIGNAN: I think they are capable of being manned up to the limit of the number of doctors and nurses. I don't have to tell you that there aren't enough doctors and nurses for our regular needs, no less for an atomic or hydrogen disaster. Insofar as pinpointing the names of the personnel for each post lo-

cated at "X" corner, I could not give you that answer.

DR. ALLMAN: These materials you speak of, are they available for civilian disaster as well as enemy action?

MR. DIGNAN: Yes, sir.

DR. ALLMAN: And this forty million dollars' worth of material that you have stored somewhere, that's in the custody of the New Jersey Division of Disaster Control?

MR. DIGNAN: No, it is owned and stored on federal property. It is owned by the federal Civil Defense Administration. The money is appropriated by Congress for that specific purpose. But if I need them for any purpose whatsoever I can draw ten per cent of that, in other words, four million dollars' worth of that supply without asking. If I can show that the rest of it is needed, then I have to get it through a request to the federal Civil Defense Administration.

DR. ALLMAN: I suppose the location of that is secret.

MR. DIGNAN: No. It's at the Veterans Administration Supply Depot in Somerville. It's no secret at all.

DR. ALLMAN: And it is in the custody of the Veterans Administration?

MR. DIGNAN: Yes, sir.

DR. RUOFF: If you were not available, who else in line would ask for the balance of the 90 per cent?

MR. DIGNAN: Well, Doctor, we work on this basis, even though we do have a small staff: that, for example, right this minute I have a duty officer who must be available for any emergency and it is his job to see that my staff gets to our State Control Center at West Trenton. That duty officer would then be in charge.

DR. LIVA: You mentioned 200-bed hospitals. Are there more than one 200-bed unit hospitals available?

MR. DIGNAN: If we needed them, yes.

DR. ALLMAN: In the state?

MR. DIGNAN: At Somerville. The federal Civil Defense Administration just last week made one available to us on a loan basis. I have not been able as yet to figure out what I'm going to do with it and how we are going to use it, whether it will be for exhibition purposes or for training. It's a mass unit multiplied three and a third times; it's a 60-bed Korean hospital. It took trained personnel four days to put it up. I have calculated how long it will take to put up this 200-bed hospital. Under a regular eight-hour day, it will take eight competent men two working weeks to do it; in other words, ten days.

DR. LIVA: To set up the 200-bed hospital.

MR. DIGNAN: That's right.

DR. LIVA: How many 200-bed hospitals are there?

MR. DIGNAN: I couldn't tell you. We have had two on order for two years. We have not received them yet. The State of New Jersey has ordered them and will pay for them when they arrive.

DR. ALLMAN: How valuable are they going to be if it takes two weeks to set them up?

MR. DIGNAN: I don't know how many there are now. I think there are 37 at Somerville. I think 12 of them are now complete and ready to be used. The balance are coming in all the time—the balance of the supplies, I mean, to make up the hospital.

DR. LIVA: To make up the hospital, but they haven't been completed as a unit.

DR. DIGNAN: I think 37 are.

DR. ALLMAN: How long did you say it would take to set them up?

MR. DIGNAN: I don't know except from what I've heard from the experience that other state directors have had. I'm going to find out, though, in the next two months, because I'm going to take that hospital and possibly set it up there. Certainly there will be an invitation to the Medical Society to come look at it and tell us what is right with it, what is wrong with it, how to operate it.

DR. LIVA: The criticism I have heard of the 200-bed hospital in the package unit is the way it is packaged. To disassemble it and set it up would take a certain length of time that would seem to be quite inappropriate for its use in any immediate catastrophe.

MR. DIGNAN: Well, that may be true. I hope it isn't, because, after all, you couldn't wait that long. But I think perhaps by practice, by taking it and setting it up and pulling it down and setting it up again maybe we can cut that time down.

DR. ALLMAN: Mr. Dignan, are you acquainted with the fact that such a unit was demonstrated on the Atlantic City beach in conjunction with the 1955 A.M.A. convention?

MR. DIGNAN: Yes, sir.

DR. ALLMAN: It didn't take them anything like that length of time to set it up. They didn't get permission until about ten days beforehand to set it up.

MR. DIGNAN: I think all they did, Doctor, was to take parts of it for an exhibition. I don't think they set up the whole hospital, because, for example, your surgical instruments are in Cosmolene. Just washing those takes time. A 40-watt generator is a big piece of equipment. You need it to operate your x-ray and your whole lighting system. There is a big wiring job too. Perhaps what they did

was just to take parts of it and set it up to show. Actually it would take eight men, two weeks. That's what I have been told. There is one set up and ready now in Pennsylvania, and the man who set it up told me that. I'm not taking his word; I'm going up to see it.

DR. LIVA: Aside from that, what other equipment do you contemplate obtaining?

MR. DIGNAN: Well, it is rather difficult to get municipalities or the state to purchase additional medical supplies when everyone knows that the federal government has stockpiled that tremendous amount. So far as I know, the state has no further plans for stockpiling, with the exception of radiologic monitoring instruments. There are 80,000 on order by the FCDA,* and those instruments will be given to the states. How long it will take, I don't know.

DR. LIVA: You mean there is a large supply of medical equipment on hand with the federal government?

MR. DIGNAN: That's right.

DR. LIVA: But has not been called for by any of the municipalities or the state?

MR. DIGNAN: They can't call on it unless there is a disaster. Suppose you were the mayor of your town and you knew there was that amount of supplies stockpiled and purchased by the people of the United States. It was available in case of disaster. Wouldn't you think it would be kind of foolish for you to purchase for your town additional medical supplies?

DR. ALLMAN: The unfortunate part of the medical supplies that your town purchases is this. If anything happens to your town those medical supplies won't be much good to you; they will be good only for the other fellow.

MR. DIGNAN: That is why we dispersed the 400 units that we have in 30 different locations. They are not within any big city. So that we could move them in. Somerville is pretty good from a target standpoint. It is far away from any attack area, you might say.

DR. RUOFF: Why would you expect the federal government requires you to ask for permission beyond ten per cent? For what other purpose would you use these materials? What does the federal government have in mind keeping its toe-hold on the 90 per cent?

MR. DIGNAN: Those supplies might be needed in Massachusetts or in Pennsylvania. They are not just for New Jersey.

DR. RUOFF: Then we really have only four million dollars' worth of supplies.

MR. DIGNAN: No, sir. I can ask for more. And also in addition to that there are other locations. I don't remember all of them. But I know Mechanicsburg, Pennsylvania and Ellenville, New York. There are in warehouses in both of those places a similar amount of stockpiled medical supplies.

DR. RUOFF: Who is actually responsible for the medical care of the citizens in a disaster?

MR. DIGNAN: The medical director or his staff member under the Civil Defense Director.

DR. RUOFF: Who in the local community would act, *per se,* to get this thing started?

MR. DIGNAN: The mayor is responsible. Under the law it is the mayor's responsibility to appoint a civil defense director. It is further his responsibility to see that that civil defense director sets up plans and gets an organization. In that organization you have key people. You have the police chief, you have the fire chief, and you have the medical director.

DR. RUOFF: How have the communities been cooperating with your Department?

MR. DIGNAN: I think very well, but certainly we need more personnel.

DR. BETTS: You are always a great person for complimenting someone, I remember from many other talks. How many separate civil defense units do we have in the state?

MR. DIGNAN: 567.

DR. BETTS: How many of those have appointed medical directors?

MR. DIGNAN: I can't answer that.

DR. BETTS: Well, we have 21 counties and each county is supposed to have a medical coordinator. Do you know how many counties have appointed medical coordinators?

MR. DIGNAN: I think all of them have.

DR. BETTS: All of those 500-some municipalities too?

MR. DIGNAN: I know there is one in Burlington.

DR. BETTS: Yes. All of these 500 municipalities have civil defense medical directors, don't they?

MR. DIGNAN: No, I wouldn't think so. Many of those 567 municipalities don't have doctors.

DR. BETTS: Do they all have civil defense directors?

MR. DIGNAN: Yes, they do. I could give you the list, if you'd like it.

DR. LIVA: Are they active?

MR. DIGNAN: Some are, some aren't. I would say that of the 567 there are probably 350 that are active.

DR. LANCE: I think this questioning has developed certain ideas which might be new. Doctors are very much interested in the individual or the mass human at the time of the disaster, and I think the doctor and the Medical Society and Dr. Betts are inclined to pin-

*Federal Civil Defense Administration.

point civil defense and disaster control in terms of medicine. Mr. Dignan has pointed out the responsibility for the organization of civil defense rests with the mayor of the community. The medical aspect of civil defense is only one facet. Mr. Dignan, could you elaborate on the whole picture of civil defense as it involves a community?

What is the first thing that happens in the community when there is a disaster, either civil or military? Who goes into operation? Who directs it? Where does medicine come in? And in moderately reasonable order, what goes into operation first, and where does medicine come into the picture?

MR. DIGNAN: Well, I would divide it, Dr. Lance, in two ways: First, by natural disaster; and secondly, by, of course, a war, an enemy-caused disaster.

Under a natural disaster, the state of disaster must be declared by the local civil defense director or it may be declared by the Governor if it covers a large area.

DR. RUOFF: How would you define 'disaster'?

MR. DIGNAN: Disaster simply means this: that the resources of that community are not sufficient to take care of the event. It may be a fire, it may be an explosion, it may be a train wreck, it may be anything. That must be a decision on the local level, the defense director's part. Once he declares a disaster, then Civil Defense is in authority and his staff goes to work. If there is need for medical care, the medical director and his staff get the job. If there is need for fire, the fire chief comes in. If they are all needed, they all go to work. That's stemming from the local, from the municipality.

The county under the law is a coordinating agency. The staff on the county level tries to get assistance into that municipality if the town calls upon the county to do so. And in a sense that is my job, to do it in case that county doesn't have sufficient resources or personnel.

So that it isn't just a local or municipal responsibility, it isn't a county responsibility, it isn't a state responsibility or a federal responsibility. Everybody is trying to say: Let George do it. I have a habit of criticizing the federal Civil Defense Administration in a constructive way. They have their problems and so do I. I get a great deal of brick-bats from Dr. Betts here and a few of the county and municipal people.

This is an American problem; it is not just an individual medical problem or a fire problem or a police problem. It is defense; it is national defense as far as any war is concerned. Everybody will be concerned with it.

DR. LANCE: Is it true that the mayor or the director of civil defense is responsible for initiating training programs not only of medicine but of fire and sanitation and so forth?

MR. DIGNAN: Yes, sir.

DR. LANCE: Whose responsibility is it to initiate training programs?

MR. DIGNAN: It is the director's responsibility on the municipal level, plus our own on the state level. We try to do our best in supplying—if a municipality requests training, no matter what it is, we try to do our best to see that they get the instructors and the necessary people to give them.

DR. LANCE: Can you insist that directors of civil defense of the municipalities initiate training programs?

MR. DIGNAN: Yes. Under the law, we could demand it.

DR. BETTS: Why haven't you done it?

MR. DIGNAN: We have.

DR. ALLMAN: Do you feel many cities are adequately prepared to take care of a disaster?

MR. DIGNAN: No, I don't think any city ever will be adequately prepared. I don't think there is any solution to that. I think we have to work towards doing the best job we possibly can. It is only eleven years since the atomic bomb first went off. Now we have a hydrogen bomb which is only 4 years old. I don't think civil defense is something that stops after you get a certain training program. We don't know even now, the effects of radioactive fallout. I don't think you doctors do either. Well, we have to keep going ahead and planning.

We are now, for example, with federal funds and federal approval, which was started by three states — New York, New Jersey and Connecticut — finally requested from the federal Civil Defense Administration that we undertake "survival plans" in metropolitan areas. Congress appropriated ten million dollars for this. We have started these "survival plans" with professional people, not amateurs, in the New York, North Jersey and Philadelphia-Camden areas, with two top engineering firms in the country under contract.

The survival plan might mean evacuation, it might mean strategic tactical, partial evacuation. It might mean shelter. We don't know. But what we are hoping is that after these studies are made at least we will be able to say to the residents of New Jersey, New York and Pennsylvania that here is a study that has been made and a plan that is offered to you.

It might be shelter. If it is shelter, there have been estimates that it would cost from four to seven billions of dollars over a course of five years to provide adequate shelters. It

is up to the American people whether they want to spend that money.

You can readily understand the problems and the complexities that might occur in an evacuation of such an area as the populated three and a half million (60 per cent of the population of New Jersey) in the five counties in north Jersey. This does not take into consideration the population of New York City. I don't know whether it is possible.

We are undertaking those now to come into the medical part of that plan. If you do, if you are going to move people, then whether you move them on the basis of a strategic two or three weeks or months ahead of time or whether you do it quickly, you still have to take care of those people; you have to feed them; you have to see about their sanitary conditions; you have to see about their medical care; you have to look into the possibilities of the hospitals, the beds and so on. That will be part of this over-all study. The first phase of it is to be completed by May 31, 1956. This will be a definition of the problem.

DR. BETTS: If The Medical Society of New Jersey has a responsibility in doing something about this, I think we should be doing it.

Whose responsibility do you think it is to train the physicians, for instance, as Colonel Shaeffer was telling us tonight, in taking care of debridement; Dr. Fitts and his ideas of care of fractures, which are foreign to much of the thinking of many of our physicians? Whose responsibility do you think it is to do that? Is it the Medical Society's responsibility? Is it the state Civil Defense Department's responsibility, or is it a federal responsibility?

MR. DIGNAN: It is the medical profession's responsibility to do the training. Who else could do it?

DR. BETTS: The Department of the Army and the Department of the Air Force and the Department of the Navy certainly have had far more experience in large scale disasters than have any group of physicians in the United States. It would seem to me that their training and their capabilities should be exploited. In the Walter Reed School, for instance, many manuals are available at the present time. The Department of the Army should be the proper department to take care of that training, at least institute and lay out the courses.

MR. DIGNAN: I think you are right, Dr. Betts. I didn't mean just simply The Medical Society of New Jersey or the national association. Certainly the Public Health Service, the Department of Health, Education and Welfare on the federal level, all of the military services, a great deal of the information which would be necessary must stem from the Atomic Energy Commission. Also our state's Department of Health here in New Jersey has responsibilities. And I don't think it is any one, but I think it is the profession as a whole rather than just The Medical Society of New Jersey.

DR. LANCE: The normal training of any physician would qualify him to treat any kind of a wound within the limits of his own medical knowledge. The civil defense program certainly can't teach a man how to do a debridement. He can get it from the medical profession. That is his own responsibility. The Civil Defense Administrator or any Civil Defense Director is not responsible for telling a technician whether there are typhoid bacteria in water. It is not their responsibility to train them to do that. That is a purely professional problem. The organization of those facilities may be another matter. You can do a debridement; Mr. Dignan can't. He would not know how. When you talk about responsibility for training, that is a purely professional problem which is, if you want to say, inherent in every physician's training. But the organization of the team is different. It is up to the local director of civil defense to say to his medical director: it is your responsibility to get these teams together—a surgeon and an assistant or a medical man to watch the pollution or a public health man. I don't think that is anything other than a professional problem.

DR. ALLMAN: I take it there is a lack of interest on the part of the average civilian doctor. Have you any suggestions about how the doctor can be made aware of his responsibilities to civil defense?

MR. DIGNAN: No young husband becomes concious of obstetrics until his wife becomes pregnant. It is going to take a disaster to get them interested.

DR. ALLMAN: That is a little late. The time for us to do it is now. We can't wait for the disaster.

DR. LIVA: Dr. Lance said that the state, when asked and called upon for training instructors, was willing to offer training instructors, thereby they assume some responsibility in initiating training programs. Now, on the state level there is a medical aspect and a medical responsibility. Is not that medical echelon on the state level responsible for initiating medical training programs?

MR. DIGNAN: Yes, sir.

DR. LIVA: And then supplying the personnel.

MR. DIGNAN: Yes, sir.

DR. LIVA: Now, on that basis how much

training personnel do you have available to go out in the field, as it were, to initiate these training programs?

MR. DIGNAN: Well, I would say that we only have certainly those with few exceptions —we only have those members of your profession who are willing to give voluntarily their time.

DR. RUOFF: How are they organized?

MR. DIGNAN: We have had a number of training program in the medical service, particularly in radio-active fallout, treatment of foods, and how you treat victims. Insofar as teaching a doctor what to do, I don't think that, as Dr. Lance mentioned, that that is our job. It's an organizational program.

DR. LIVA: Doesn't that organizational program start at the state level?

MR. DIGNAN: Yes.

DR. LIVA: I am trying to find out how much is there at that state level.

MR. DIGNAN: We have responsibility (as far as the medical direction of the civil defense program) under Dr. Bergsma in the Department of Health. It is his responsibility. Actually a medical plan has been published for years. Over 50,000 of those plans have been distributed throughout the state and yet I doubt if any doctor in this room has read it, except you.

DR. ALLMAN: That is my concern, Mr. Dignan. Here we've got a thousand doctors in town right now and civil defense is certainly of great importance. Here is a symposium and there are 42 people in this room, not half of them are doctors. I'd like to know how we can create more interest in the doctors as to their civil defense responsibility. I want to know what you are doing about it and I would like to know why more isn't being done; and if it is necessary, why legislation isn't drawn up to put some teeth in this situation. What can we do to get these doctors interested?

MR. DIGNAN: Well, that's not only a tough problem as far as the medical profession is concerned, it is a tough problem throughout the whole civil defense program. I don't know the answer. We have done all we can with the funds we have in trying to promote this educational program of public relations and public information. We have used the radio; we have used television. For the month of April 1956, we shipped out of my office a million pieces of civil defense literature throughout New Jersey.

I do know that other countries have gone in for drafting. In Sweden everyone from fifteen years of age on has to spend 60 hours the first three years in training. They can choose their own service. After the first three years they can drop down to refresher courses. And that is a draft. I don't think you will ever get it in this country because you know it is even difficult under the present system to draft boys for the military service.

DR. RUOFF: We have heard a lot tonight apropos to the matter of every doctor pitching in and doing his bit in case of disaster. You say that the matter of a disaster depends on the Governor or your Department or whatnot before a disaster is declared. Up to such time as someone declares a disaster, take the obstetrician, the skin specialist, the what-not, ask him to treat a fracture and his first consideration would be "well, I don't know how; and what is going to happen if a disaster isn't declared and I become liable for malpractice?" Is there anything in the law as it now stands that gives him that privilege with or without a disaster being declared?

MR. DIGNAN: I don't believe so.

DR. RUOFF: Don't you think that would be a deterrent?

MR. DIGNAN: Well, of course, that would be your profession and your responsibility if a disaster is not declared. But if a disaster is declared and you happen to be taking a loyalty oath and you have signed up as a doctor in the medical program of your municipality, then anything you do as a doctor, you cannot be sued for it and you are not held personally responsible.

DR. RUOFF: Yes, but disaster can arise within a few hours. It would be a day or two before the Governor declared it a disaster.

MR. DIGNAN: No. The local director can declare a disaster on the spot at the time.

DR. RUOFF: Are they all so equipped to do?

MR. DIGNAN: All they have to do is to proclaim it. And let me say one more thing. Civil defense has no business interfering with regular departments of government. We don't want to get into normal police work, normal fire work or normal medical work. You would be the first to want civil defense to stay out of your profession unless a disaster is declared.

DR. BETTS: May I refresh your memory, sir? About two years ago a little hamlet by the name of Chatsworth in the woods in Burlington County had a fire roaring down on it and when the fire got on the outskirts of the town the Civil Defense Director called up the County Coordinator and said: "How the hell do you declare a disaster?"

MR. DIGNAN: I remember that. The Civil Defense Director left town, but the County Coordinator called me and asked me to declare a disaster, which, if you recall, I did, which I have the right to do. It is delegated power from the Governor.

DR. LANCE: Could you tell the panel some of the things that I have heard you tell about predictions of impending disaster, particularly in the matter of floods. It might create in their minds perhaps a little better impression of what the Division is doing.

MR. DIGNAN: After the floods of last summer, which was the first experience that I had had directly as a Civil Defense Director, we had had two other disasters but never any such thing as the floods that occurred in the Delaware Valley, on the Ramapo and Passaic Rivers. And I found that there are ten or twelve different agencies, including state agencies and federal agencies, that have something to do in disasters, whether they be a hurricane, forest fire, a flood or what not. All of them are working kind of independently of each other, you might say even without speaking to each other. Some of them have to do with warning, like the U. S. Weather Bureau, the U. S. Geological Survey, the Coast Guard, the Corps of Army Engineers, Philadelphia District and the New York District, the Water Policy Commission of the State and the Delaware Bridge Commission.

So I thought it might be a good idea if we could get all of them together so that for one thing at least we would be speaking the same language and also giving out warnings before a hurricane or a flood. Those agencies had resources that could be used after the fact, so to speak. I have gotten them all together; we have all agreed on a standard operating procedure. It is now in the process of being printed.

The U. S. Weather Bureau, as far as warnings are concerned, will be the agency that will decide what warnings will be given out. Of course, they are anyway, but they are going to channel the necessary information through our State Control Center to radio stations, to newspapers and, if necessary, to the individuals who may be in the area. Since that time they have increased their possibilities of warnings by 40 radar stations running from Puerto Rico to Maine. They have new equipment and we can get warnings every hour.

I'm not much of a weather man, particularly in so far as forecasts are concerned. I would much rather be able to see the storm and know where it is rather than have someone tell me that the pressure goes this way or the temperature goes that way and therefore the storm is going this way—usually they don't. We had that experience with "Diane" and a couple of others which hit into Cape Hatteras and then made a circle and came right out again. If you tell people the storm is coming and it doesn't come, they get mad at you. And if you don't tell them it is coming, and it comes, they are madder.

Through the coordination of these agencies we will be better equipped to give people information and I certainly hope to be able to take care of people if an actual hurricane or storm occurs.

THE MODERATOR: Ladies and gentlemen our time is at an end. I think this is very interesting, but I think that we should close this, and I would personally like to express my appreciation to you, Mr. Dignan, for coming here and being so gracious in answering our questions.

I certainly am grateful to the members of the panel and I would like also to compliment Dr. Betts on putting on a very interesting program. Thank you very much.

(The meeting concluded at 11:25 p.m.)

GENERAL SESSION

Monday Evening, May 14, 1956

The General Session of The Medical Society of New Jersey convened at Haddon Hall on Monday evening, May 14, 1956, at 8:50 p.m., Dr. Vincent P. Butler, President of the Society, presiding.

OUTGOING PRESIDENT BUTLER: May I welcome you all to the General Session, and without any further ado present to you for his inaugural address, our President, Dr. Lewis C. Fritts. (Applause)

INCOMING PRESIDENT LEWIS C. FRITTS: Mr. President, very welcome Guests, Ladies and Gentlemen: There are a few times in the course of the span of life when events of high character and significance prove too much for acknowledgment in words. This is one of those times for me. Medicine is the profession of my choice and of my affections. I consider it a privilege merely to be part of Medicine, and to be permitted to serve in the furtherance of its aims and ideals. It is therefore the more overwhelming to me to be given the honor which is now mine.

Humbly and gratefully I enter upon my duties as the 164th President of The Medical Society of New Jersey. For one hundred and ninety years our Society has enjoyed an illustrious and a fruitful life. It will be my purpose and my goal, God helping me, so to serve as to preserve and advance the name and fame of this Society, and thus to manifest in action the appreciation which I cannot express in words.

It is my understanding that in assuming the duties of the presidency of The Medical Society of New Jersey, I become its titular head. I am under no delusions as to what that means. For one year I shall have the privilege and the responsibility of being your chief officer. I shall have a part in evolving and an official voice in proclaiming the programs and policies which the Society itself will adopt. I do not deceive myself with the thought that for this year I am the Society. I would not accept the presidency were such the circumstance. This Society is made up of some six thousand members, each one of whom holds equal membership with me. And with that membership goes equal responsibility for the welfare of Medicine and of the people whom we serve. I shall be for this year the representative and the servant of all our members. But this year will be only as productive of good as all our members are constructively active. Therefore, I call upon you here present as I call upon our members everywhere—to give of your best, so that, working together industriously and harmoniously, we may compile a record of genuine accomplishment.

That is a point that I want to emphasize. The control of this Society rests with the membership. No set of officers—regardless of how diligent they may be—can supply for this Society much more than advice and encouragement. Polices are of importance only when they are effectuated through universal cooperation. The zeal and industry of members individually will set the limits to our collective accomplishments. Understanding that, let us work together through this year, each member regarding himself as just as sternly bound by duty as is the president or any other officer. In that spirit we will really have organized medicine in New Jersey. Only working in that spirit can we do the job—the big job—that is ours to do.

As others have remarked before me, the problems of Medicine have changed and are changing with the times. Once the gravest questions confronting physicians arose out of the lack of scientific knowledge and effective instrumentalities for overcoming disease and deferring death. Now that we are in position, as the result of more accurate knowledge and advanced scientific equipment and procedures, to bring to our fellowmen the advantages of sounder health and longer life, new problems confront us. Typical and most pressing is the problem of the cost of medical care for those whose private resources are insufficient to meet it. This problem of the economics of medicine is by no means the exclusive problem of the medical profession. It is the problem of our entire American society. But we must play our part—as doctors and as citizens—to arrive at a sound solution, or we run the risk of having others work out the solution for us, with consequent deterioration of the standards of medical care and invasion of the authority and freedom of our profession.

We of the medical profession must be active and vigilant not only to be proficient in dealing with the scientific aspects of medical care, but with the economic aspects as well. We are disturbed when others not of the profession arrogate to themselves leadership in the fields of medical practice and medical economics. But they have assumed their position largely by our default. If we want to enjoy leadership, we must work to retain it. Now it is not enough for the doctor to give his time and efforts to the care of the patient. He must diligently and humanely apply himself to understanding and solving the complex problems of the economics of modern medicine. Unless he does so—and soon—he will no longer be left in untrammelled control of the care of his patients, despite the fact that he alone is qualified to decide what care should be given and how it should be rendered.

The day of individualism is dead. In these times no one but a fool believes that he can be a law unto himself. This is the era of accomplishment through organization. It is time for us, in reality rather than in name, to organize medicine. Only in this way can we protect Medicine from progressive encroachment and deterioration. Only in this way can we safeguard the kind of medical care that makes our country outstanding in the world.

and makes us the most successful and fortunate of practitioners.

In The Medical Society of New Jersey today we need men and women of unselfish dedication and action. We need men and women of vision and industry, to take their places on our committees and to do their best to do their jobs. We need men and women who in their daily practice will deal with their patients not only so efficiently but so intelligently and compassionately that they will make each patient a stalwart admirer of the entire profession. We need men and women of such character and worth that each will be an influence for better public relations with all his patients. In short, we need men and women who love medicine and their fellowmen, and who serve what they love unselfishly.

The time is ripe for rededication and rebuilding in every phase of American life. As members of the medical profession let us pledge ourselves to retain the best of our distinguished past and to build enduringly for the future. In that way we shall fulfill our obligations and our duties, not only as practitioners of medicine, but as citizens of the America of today.

I shall be honored to work with you.

OUTGOING PRESIDENT BUTLER: Thank you, Dr. Fritts. I think you have all enjoyed this inaugural address. I know I did. We can all profit by heeding this advice, Dr. Fritts. I'm sure we all will.

In the past we have had a different format on this occasion. We are now trying an innovation. We will now present our "Town Meeting of the Air." And now I want to turn the meeting over to my good friend and neighbor, the Honorable James F. Murray, the Senator from Hudson County.

Senator Murray, will you take over?

(Applause)

SENATOR MURRAY: Thank you, Dr. Vince Butler, Good evening, Ladies and Gentlemen.

I welcome you to America's "Town Meeting of the Air." Many of you have heard Town Meeting over one or more of the 330 stations of the great ABC Network. Before going into our formal program we do like to acquaint you with the format and the brief formalities and technicalities which we naturally observe in order that the program be interesting and that it move along smoothly.

(Senator Murray then explained the procedure for audience participation.)

(ON THE AIR)

SENATOR MURRAY: Welcome to America's Town Meeting, transcribed from Atlantic City. This is James F. Murray, Jr.

Our subject: "Why the Furor Over Fluoridation?"

Our speakers; Mr. Melvin Klerer, Physicist, Secretary of the Interprofessional Conference on Fluoridation, and member of the teaching staff of City College. And Mr. Earl Ubell, Science Editor of the *New York Herald Tribune*.

ANNOUNCER: Tonight's Town Meeting is a feature of the General Session of The Medical Society of New Jersey, which is holding its 190th Annual meeting at Haddon Hall in Atlantic City. Founded in 1766, while New Jersey was still a colony, The Medical Society of New Jersey is the oldest of its kind in the western hemisphere. Its founders—who described themselves as "practitioners in physic and surgery in eastern New Jersey"—associated themselves "for the advancement of their profession and the promotion of public good." Since 1766, the Society has been faithful to this twofold dedication. Fourteen members signed the old instrument of association. Today its membership totals six thousand. Thirteen hundred physicians are gathered here for scientific sessions, business meetings and social events. Tonight the incoming President of The Medical Society of New Jersey, Dr. Lewis C. Fritts of Somerville has delivered his inaugural address. Our Town Meeting will constitute the second portion of this evening's program.

Now to serve as moderator of our discussion, here is James F. Murray, Jr., attorney, author and lecturer. Mr. Murray!

SENATOR MURRAY: One of the most perplexing modern controversies raging in the United States in the field of public health is the question of whether to fluoridate the water supply of our cities in an effort to prevent or reduce tooth decay. This issue directly involves millions of Americans. Its ramifications include delicate points of finance, religious freedom, minority rights, and constitutional law.

Perhaps the only unchallenged fact of the entire debate is the enormous extent and damage of tooth decay among our citizens in every walk of life. Dental decay afflicts more than 80 per cent of our youngsters even before they begin their first grade grammar school. It accounts for a staggering proportion of this nation's yearly dental bill of more than one hundred million dollars.

Would fluoridation of our drinking water effectively eliminate this hazard to our health? The experts are sharply divided and the differences of opinion become more intense as city after city comes face to face with the problem.

America's Town Meeting now brings you two nationally known authorities to present both sides of the question: Why the Furor Over Fluoridation? For the affirmative, the distinguished Science Editor of the *New York Herald Tribune*, Mr. Earl Ubell.

MR. EARL UBELL: Thank you, Jim.

I will do the best I can to display the favorable as well as the derogatory evidence that has come before me as a science editor on the subject of fluoridation. Not everything is known about this measure that reduces dental decay, but enough is known to advocate it. In fact, 1300 cities have adopted the measure.

Few scientists would assert that the lack of fluoride in the diet is the sole cause of dental decay. It is well known that a diet with too much sugar contributes to dental decay. Everything short of a Volstead Act has been tried to have the public cut down on sweets. Heredity is important, too. Recent experiments at Columbia University indicate that lack of chewable hard food in civilized diets fails to give the teeth sufficient compression to help them maintain metabolism.

So if fluoride does anything, it acts as a contributing factor to the structure of teeth. But how it acts to prevent decay is still somewhat of a mystery. I might add that this is not the first substance whose benefits have been used prior to its full comprehension of knowledge.

Black and McCay published the first major report in 1916 which tied the water supply to teeth. They discovered that in certain areas the teeth mottled; that is, they had dark brown stains which were quite disfiguring. By 1931, however, enough about the chemistry of fluorine was known to pin the mottling on the presence of small but significant amounts of fluoride in the water supplies. Bauxite, Arkansas, for example, had 13 parts of fluoride in every million parts of water.

It was only ten years later that H. Trendly Dean of the Public Health Service substantiated an early impression held even in the last century, incidentally, that fluoride reduced tooth decay. He examined children in naturally fluoridated areas and found that if the fluoride was at a level of about one part per million it reduced tooth decay by up to 60 per cent compared to non-fluoride areas. At the one part per million level there was no disfiguring brown stain, only occasionally white flecks that could be detected only under a special light used by an expert.

A controlled experiment was then suggested. Pairs of towns were selected. One was fluoridated, and the other not. In all there were four such experiments, the best known at Kingston and Newburgh, New York. In each case the reduction of dental decay after the first few years was comparable and up to 70 per cent compared to a controlled city. In older age groups the reduction was less, presumably because their teeth had not had the benefit of fluoride at an early age when it is incorporated into the teeth.

In each case the degree of mottling was less than that which could have been detected by the ordinary observer.

Another study involving Colorado Springs with 2.6 parts of fluoride per million in the water, and Boulder City with practically no fluoride shows that these benefits continue up to the age of at least 45, the last age covered by the investigation.

All these experiments, of course, suffer from the extreme difficulty of measuring tooth decay uniformly, and this is the greatest criticism that could be made of them. However, in New York extensive precautions were taken to exclude such errors, including random x-ray pictures of the teeth.

Another question might be: Is fluoridation safe enough for children and adults? Nobody can prove that anything is one hundred per cent safe. If the most delicate measuring instruments, including statistics, laboratory technics are unable to disclose any harm, I believe one is able to proceed on the assumption that it is safe enough.

Schlesinger and his associates carried out extensive medical and laboratory measurements on children in the Newburgh-Kingston study and found no differences in growth, weight or other physical features. The Public Health Service examined in detail more than one hundred long-time drinkers of fluoridated water in Bartlett, Texas, which has 8 parts per million of fluoride in water, and Cameron, Texas with less than one part per million and found no abnormalities traceable to the fluoride except a slight increase in the density of bones, which had no clinical significance.

But these are admittedly small numbers. The Public Health Service has, to remedy this, selected in a random way 16 fluoride cities and 16 nonfluoride cities and compared the death rates involved. There were more than two million people covered by this investigation. They found no statistically significant difference in the death rate at all ages of five major causes of death; that is, of the heart, kidneys, cancer, liver and the brain. There was a greater over-all death rate in the fluoride cities, but this was not statistically significant. I believe that although this number is slight, additional statistical studies of the same nature should be carried out to prove that the difference is a true statistical variation to alleviate the fears of those who are super-critical.

Laboratory and clinical studies on animals indicate that no abnormal amounts appear at the proposed levels of fluoride, but only at

much higher levels of ingestion. Studies of kidney function in the aged and in damaged animals show no lowering of the ability to excrete excess fluoride.

There have been scattered reports of clinical cases of fluoride poisoning, particularly by Dr. George L. Waldbott of Detroit, who has 12 of his own cases and 50 more collected by questionnaire. Dr. Waldbott has not proved to the satisfaction of his local medical society that the cases were indeed caused by fluoride in the water supply or by other conditions, particularly those of a psychosomatic nature.

Fluoridation is probably cheaper by a factor of ten of any other way of getting minute amounts of fluoride to growing children.

Not everybody opposed to fluoridation is a crack-pot or a quack. Some are quite sincere. One is a good friend of mine. But they individually or collectively have not produced on their own any evidence—and I have to repeat that word evidence—that fluoride is not efficacious or it is harmful. Their objections are mainly theoretical, and if I may say so, to paraphrase an old Chinese proverb, one good experiment is worth one thousand opinions. (Applause)

SENATOR MURRAY: Thank you Mr. Ubell. Our second guest on Town Meeting for a sharply divergent opinion is Mr. Melvin Klerer, Doctor of Philosophy and physicist, member of the teaching staff of City College of New York, Secretary of the Interprofessional Conference on Fluoridation, and author of *The Fluoridation Experiment* which appeared in Contemporary Issues, an international periodical. Mr. Klerer! (Applause)

MR. MELVIN KLERER: Thank you, Mr. Chairman.

Since it is such a controversial subject, let me state at the outset that I speak as an individual, not as a representative of any particular organization or institution.

The continuing controversy, for some years now, over the merits of fluoridation as a public health measure, has been marked by much propaganda, little data, and the lack of adequate scientific discussion. The methods used to foster its adoption, the reluctance of responsible government scientists and officials to engage in public discussion of this issue, and the various political pressures exerted, lead to the unavoidable conclusion that this scheme has left the realm of purely scientific controversy. It has been, in fact, transformed into a political issue, with all the encumbrances of political interest and motivation. The temper of this controversy may perhaps be gauged by noting that a prominent member of New York City's Board of Health has recently been quoted as characterizing the opponents of fluoridation as "fuzzy-minded nit-wits" who had been swept "off their feet by emotional ignorance." In turn, the very little coverage given by the press to the general opposition viewpoint has made crude emphasis of the charge that fluoride is a deadly poison, not fit for human consumption. Oversimplified and inadequate as these statements are, as representations of both sides of the controversy, I have no hesitation in declaring that the weight of truth lies with the latter charge and that the serious toxic consequences of fluoridation will, in the passing years, become evident on a mass scale.

The main premise of the fluoridation hypothesis is that the rate of dental decay in children will be substantially decreased if they take in fluoride at a level of 1.5 parts per million from their drinking water. But the published data does not support this conclusion. The reports, as inadequate as they are, imply that the claim of dental benefits is a spurious contention based on the inadequate studies, factitious and self-contradictory data, and the private speculations of a handful of individuals. Such studies have been contradicted by disinterested researchers. Concomitant to the claim of dental benefit for children is the equally absurd contention that the rate of dental decay in adults can be expected to decrease if they are exposed to fluoridated water at the recommended levels. Since no proper investigations have been made on adults exposed to this level of fluoride, this constitutes mere wishful thinking. Actually, the few studies made on adults, in communities with amounts of indigenous fluorides slightly above the recommended level, show that the adult *dentition is severely damaged by fluorosis.*

Recently the claim has been made that children exposed to the recommended level of water-borne fluorides will not develop the initial symptom of generalized fluorine poisoning: mottled teeth. Mottled teeth are characterized by dull, chalk-white irregular patches or striations and loss of normal translucency so that they appear unnatural. In later life they may develop a permanent discoloration varying from dark brown, almost black, to yellow. In severe cases the enamel may be pitted and corroded making it difficult to fill decayed teeth due to the ensuing structural weakness and fragility.

It has been contended by the proponents of fluoridation that objectionable or disfiguring mottling will not occur with fluoridation. It has been asserted that teeth exhibiting the milder forms of fluorosis are more beautiful than normal teeth. This is controverted by the mass of published data which show that a very large proportion of the children under-

going fluoridation exhibit forms of dental fluorosis which are highly undesirable—frequently the appropriate word is "ugly." This condition will worsen as the children advance into adulthood. Children exposed to poor nutrition can expect to suffer more severely from this condition in addition to other more detrimental physiologic effects.

Equally ludicrous are the contentions that all fluoride compounds in food and water are physiologically identical, and therefore any kind of soluble fluoride compound can be dumped into the water supply. Not quite so humorous in its effects is the supporting argument that none or very little of these fluorides will be retained in the body—the major argument against possible toxic consequences. Thus, together with claims that fluoridation does not harbor any medical risks, all the supposed benefits and assurances about fluoridation must be regarded as in error, founded either on mistaken inferences or in contradiction to the actual studies available.

(Applause)

SENATOR MURRAY: Thank you, Mr. Klerer. There, you see, Ladies and Gentlemen, two sharply contradictory viewpoints.

I think perhaps we might immediately plunge into our basic discussion this evening by trying to relate these two opening statements. And, Mr. Ubell, you have been listening to what has just been said by Mr. Klerer, and I wonder if you would care to comment upon his opening remarks, particularly with respect to the attacks which he made upon the efficacy of fluoridation and the safety of fluoridation and the contrast which he drew between what he described as lack of adequate scientific discussion and uncorroborated and contradictory studies.

MR. UBELL: Mr. Klerer said a mouthful. And I would like to say, first of all, that I was sorry to hear him use such words as "absurd" and "ludicrous" in describing these very good experiments which I was discussing. The men who did them are of the highest order of scientific competence. They work for the United States Public Health Service and they have given their lives to scientific research.

The word "mottling" has been bandied about to cover all ranges of dental disfiguration. This includes the very severe blackened teeth that were first seen by Black in 1916, to the almost imperceptible white flecks that can be detected only by polarized light. To lump these two opposite types of dental change under one heading is the same thing as, I think lumping a severe sunburn with a generalized suntan.

The severe mottling occurs only at very high levels of fluorine ingestion, somewhere between three parts per million and up. The kind of mottling which the people who have been conducting these experiments are talking about occurs only at 1½ parts per million and above, and below 1½ parts per million only 10 per cent of the children studied showed this almost imperceptible flecking.

MR. KLERER: Now, as far as mottling is concerned, I am willing to make my statements a little sharper. I not only think it is absurd, I think it is scandalous, absolutely scandalous that the people of this country should be subjected to a scheme which will cause such damage. For instance, the Public Health Service in the late '30's and in the early '40's was concerned with mottling. This arose from certain concentrations of fluorides in the water, supposedly naturally contained in certain areas. The Public Health Service sent investigators into these areas. They made a survey and reported the statistics on this mottling. May I quote some statistics and these are from the Public Health Service, principally from Dr. H. Trendly Dean, one of the men who is recognized as one of the principal proponents of fluoridation. These figures were released in 1942 and re-published in 1946. They were published by the American Association for the Advancement of Science. The Public Health Service is absolutely ignoring its own work.

Let me cite, for instance, the City of Aurora, Illinois. Aurora is used as a model city. It is the city where, it is said, there exists an optimum of reduction in dental decay. Aurora has a concentration of 1.2 parts per million fluoride supposedly naturally there in the water supply. However, when the Public Health Service investigated, they found that among Aurora children (age 12 to 14 years) 31.8 per cent exhibited what is called questionable mottling. That is somewhat of a misnomer since questionable mottling is readily observable. It usually consists of white spots or striations on the front teeth. They also found that 14 per cent of the children exhibited what is called "very mild" mottling, which I also consider to be an objectionable condition; and 1 per cent exhibited "mild" mottling, and mild mottling is quite objectionable.

In Joliet, where the fluoride content is 1.3 parts per million, there were 34.2 per cent questionably sclerosed children; 22.2 per cent "very mild"; and 3.1 per cent "mild." There were also a few thousand children with "moderate" mottling. Now, "moderate" mottling—I'm not exaggerating—is when the teeth begin to fall out.

SENATOR MURRAY: We'll continue our discussion in just a moment and announce our

prize-winning listener question after this word from our announcer.

(The announcer made a commercial announcement.)

SENATOR MURRAY: This week's winner of the American Peoples Encyclopedia is Mrs. Leroy W. Cook of Boulder, Colorado, who submitted this question:

"Isn't there a more efficient and practical method of administering fluorine to children for the few years they need it than putting it into water used for all general purposes?"

Mr. Ubell, would you care to answer first?

MR. UBELL: In my opinion, although contrary to what I said about opinions before, there is no more efficient and practical method of doing this job.

Is there another method of doing this? Yes, there are other methods; that is, distribution of tablets, putting it in milk, and selling bottled water. In each case these methods are either more expensive than using it in a general water supply or are impractical in the sense that they cannot be controlled the way the water supply can.

MR. KLERER: If I was forced to imbibe fluorides I think I would find the most welcome form of taking them would be in a good glass of French cognac. Fluorides, whether in water, in pills, in toothpaste, in milk or in what you wish, are all equally dangerous, and this is not a speculation. I draw my conclusions from the data which the Public Health Service has gathered ten years ago before.

MR. UBELL: I am going to read from the Public Health report which was published in the 1954 American Association for the Advancement of Science volume. This is the classification of each tooth according to the following scale on mottling: Grade 1, normal; 2, questionable; 3, very mild; 4, mild; 5, moderate; 6, severe.

In assigning a child to a category, they have arbitrarily adopted the simple rule that the presence of two or more teeth, characterized by a higher grade, places the child in the higher category. For instance, if most of the teeth of a certain child were normal or questionable, but two teeth were classed as very mild, this child would be placed in the category of very mild for statistical computations. And since most of the children to which Dr. Klerer referred were either in the questionable category; that is, that the scientists couldn't make up their mind whether the tooth was mottled or not, I would say that the degree of mottling is indeed slight, so slight that the average individual looking at a mouth could not detect it.

SENATOR MURRAY: Well, gentlemen, I wonder if we might move on to another aspect which I know the average layman is interested in and that is the efficiency of this proposed method in terms of preventing tooth decay and then if we can after that go on to some of the more general safety factors with respect to the charges that have been made that fluoridation damages the kidneys, that it creats tendencies to cancer, et cetera. How about the efficiency in prevention or reducing tooth decay?

MR. UBELL: I would like to summarize briefly the findings of the four controlled experiments which were undertaken. The first was in Newburgh, New York and the proportionate reduction in decay after eight years—this is after only eight years of fluoridation—was up to 66 per cent in the 9-year-old group. In Grand Rapids, Michigan after eight years in the 9-year-old group the reduction was up to 48 per cent. In Branford, Ontario in the 9-year-old group, it was up to 46 per cent. In Evanston, Illinois in the 8-year-old group it was up to 35 per cent reduction in tooth decay compared to a controlled city. In each case children of younger ages were even more greatly protected against tooth decay.

MR. KLERER: Mr. Ubell, were there any bad results in this very happy picture? If I were just to read the press all I would see emphasized is the one or two studies which seem to emphasize the *apparent* reduction. With regard to the Newburgh reports an independent study was made by the State Education Department. They went to Newburgh and Kingston and examined the children there. Their results were in complete contradiction to the official publicized study.

They found that the fluoridated children in Newburgh had a decay rate which was 50 per cent higher than Kingston, the control city. Of course, due to the varying omissions and apparently different methods of examination, the two studies were not comparable. But they also examined the children as far as their total health conditions were concerned. These were done by school physicians in each city. They found also that in Newburgh, the fluoridated city, the total health defect rate was 50 per cent higher than in Kingston. What is more startling, however, and what cannot be qualified is the amazing fact that the proportion of children under dental treatment in Newburgh is 40 per cent higher than Kingston. It would seem from this that Newburgh's children, the fluoridated children, require more dental care. Now, this is not the only incident; there are other studies. For instance there was a study in Ottawa, Kansas. The rate of decay doubled after three years. Nobody hears so much about

that. The reported results from Evanston, Illinois were very unhappy for some groups. The reported results from Charlotte, North Carolina were also very unhappy for some groups, but nobody has told about that.

MR. UBELL: In my opening presentation I referred to the extensive medical studies which were done by Schlesinger and his group on the children who engaged in the Newburgh and Kingston studies and they found no changes in growth rates, height differentials or any of the other characteristics which might have been expected to appear.

Now, with respect to the study—I won't even characterize it by a study. You will find that the report to which Mr. Klerer refers is a letter written by a Dr. Forst, head of pupil health in the New York State Department of Education. This report does not have the usual scientific controls that one would like to see in a study of this kind. It refers only to dental defects, not separating, for example, decay from crooked teeth.

MR. KLERER: Mr. Ubell, are you doubting the report, the facts and figures? There was a published report put out, a mimeographed report put out by the State Education Department. Do you challenge the facts and figures?

MR. UBELL: I challenge the facts and figures as being a scientific report.

MR. KLERER: You challenge the numbers put out by the State Education Department as being untrue. You say the State Education Department went down to Newburgh and counted the number of children under dental care in Newburgh and counted the number of children under dental care in Kingston, that their figures are not true?

MR. UBELL: No. I'm referring to your first statement in which you say that the rate of dental decay is higher in the fluoridated city than in the un-fluoridated city. If you will examine these figures as I have, you will find that the examinations in Newburgh were done by a dental technician using a probe and a mirror, who was trained to find dental decay. Those in Kingston were done by a simple oral examination of the mouth by the local school physician.

MR. KLERER: Mr. Ubell, let's be fair. I'm not quibbling about a percentage here and there. I'm talking about a study which is in blatant contradiction to the official results.

MR. UBELL: It is not a study. It never was a study. It was never characterized as a study.

SENATOR MURRAY: Gentlemen, I wonder if we could get away from the position of the seven blind men examining the elephant for a moment. I'd like to keep you in conflict, but on a little larger scale.

I have been informed that among the nation's largest cities already employing fluoridation are Philadelphia, Washington, St. Louis, San Francisco, Pittsburgh, Milwaukee, Providence and Miami. Do you have additional facts you can give us about the opinions of the professional responsible organizations of medical and dental men, whom the public looks to for guidance and advice in these communities? Has there been any production by them of statistics or results that could guide us in this problem?

MR. KLERER: Well, Mr. Murray, it is rather unfortunate, as I pointed out in my introductory statement, that fluoridation has left the realm of purely scientific controversy, in fact it has become a political issue where political pressures have been exerted. For instance it is not an accident that there has been a cleverly conceived and executed publicity campaign in the press which only emphasizes those few studies which show apparent benefits and completely ignores the mass of data which show harm.

MR. UBELL: That is not true.

MR. KLERER: It is not accidental that there has been no adequate scientific discussion on this issue. It is not accidental that the Public Health Service has held secret conferences on how to promote fluoridation. The minutes of these conferences were withheld from the public. It is not accidental that in a recent hearing before the City Council of New York, the relevant and concerned administrative bodies were not present to argue the case. You can make all sorts of excuses for this. But it is clear that political pressure has been brought to bear on this issue to lift it out of the realm of purely scientific controversy and to serve purely political purposes.

MR. UBELL: That is a slander on the United States Public Health Service which is one of the outstanding research organizations in the United States. I particularly do not see that any purpose is served by slandering such a great institution. The major medical and health organizations in this country have endorsed fluoridation either in principle or in fact. This includes the American Medical Association, the American Public Health Association, the American Dental Health Association, and I could cite many, many more.

Let us go back to the Newburgh-Kingston study on the dental decay reduction, you will find, those of you who have an opportunity to read it and send for it to the Department of Health in New York State, you will find one of the most carefully documented studies on the statistics of dental decay that have ever been made. It includes the randomization of x-ray pictures to eliminate observer bias. This

is really a careful study. You cannot compare this careful study with a mimeographed sheet of paper handed out by the New York State Department of Education in response to a simple question that tells nothing of controls, nothing of randomization, nothing of the steps taken to make this a real scientific—

MR. KLERER: Mr. Ubell, you are not answering the question. You are merely taking up time. What about the other studies?

MR. UBELL: I'll leave that to the audience. Am I taking up time to show up this—
(Applause)

SENATOR MURRAY: Gentlemen, we will continue with our program from Atlantic City after this message from our announcer.

(The announcer made another commercial announcement.)

SENATOR MURRAY: America's Town Meeting now turns to its audience for questions, and I accept the first question from the gentleman on my left. Will you tell us your name and for whom your question is intended, please?

DR. COBELBY: I'm Dr. Jack Cobelby of Bergen County. My question is for Mr. Ubell. Can you comment on the use of fluorides in vitamin preparations or in common table salt as iodides are now added?

MR. UBELL: The Board of Health of New York City found, as a result of their economic study, that it would cost approximately ten times as much to distribute fluoride in tablet form or to add it to any other material now available than it would be to fluoridate the public water supply. In addition, they point out that in distributing fluoride in this way they do not have the specific control that they might have over the distribution of the material as they would in the public water supply.

SENATOR MURRAY: Your question, please, sir.

DR. SAMUEL REICH: I'm Dr. Reich, a physician from Hackensack.

Why do lay people doubt the evidence of professional and public health authorities?

MR. KLERER: For very good reasons, sir, because in fact there exists a substantial body of data which contradicts the claims. Let me just return to the point I made before, the question whether these mild forms of fluorosis are objectionable. That is a fact which everyone can determine for himself. If this program were televised, I could show the audience the pictures of mottling. The next best thing is to give you two references. One, a book called "Fluorine and Dental Health" put out in 1942 by the American Assocation for the Advancement of Science. You will find this in your local medical library, and you go and look at these pictures and see if you can say that the milder forms of fluorosis are unobjectionable.

There is also a recent paper by E. R. Zimmerman. You will find that in the Public Health Reports in 1954. He describes "questionable" mottling; that is, he shows you sketches of this. He describes questionable mottling as consisting of two striations on the front teeth and numerous spots on the back teeth. Again look at questionable mottling and see if you think this is unobjectionable.

It is absolutely absurd to make the statement that these milder forms of mottling are desirable or even unobjectionable—absolutely fantastic and irresponsible.

DR. JOHNSON: I'm Dr. Winton Johnson, a physician from Hackensack, New Jersey. My question is directed to Mr. Ubell.

Since fluoridation has any value, it seems to be only in the young; therefore, why could it not be on a permissible basis in the milk? And how that can be more expensive than putting fluorine in all the water that is used for washing the car or watering the lawns, I cannot see.

MR. UBELL: I only refer you to the study made by the Board of Health of New York City. They discovered that testing the milk would cost the Board of Health in New York City $250,000 a year alone. In addition, the placement of fluoridating equipment in the various milk companies would represent an additional expense. Furthermore, milk companies would have to charge a one cent premium for this type of milk. Now, this might all be to the good; however, it is the feeling of the Board of Health that it would be cheaper, better, easier to fluoridate the entire water supply.

MR. KLERER: Mr. Ubell, are you aware of the large difficulty, perhaps the insuperable difficulty of properly fluoridating the complex water system of New York, especially when we are told that one part per million is all right, but two parts per million is very dangerous? Certainly you live in New York. Haven't you tasted or noted the fact that chlorine in the water in the Bronx is at a much higher concentration than in the lower part of the city? How will you regulate, how will you prevent a two-part per million dose in the upper part of New York City, considered very dangerous, and a one part per million dose supposedly not dangerous?

MR. UBELL: Two parts per million is not very dangerous. It is near the level at which one should be careful. However, I would say this, that if the water supply engineers of New York City are unable to do what other water

supply engineers in other cities are able to do, that possibly one should look for other engineers.

MRS. REICH: I'm Mrs. S. B. Reich from Hackensack. May an adult expect any benefit from fluorides?

MR. UBELL: Again I can only quote the study which was made relating to two cities; one was Boulder City, the other Colorado City. The concentration was 2½ parts per million fluoride in the water. This study covered ages up to 45. The benefits were retained to a very large extent in the fluoridated results. This is one of the few studies that was made along these lines. I was endeavoring to answer the lady's question as to whether adults could expect any benefit, and according to this study they might expect some benefit. Not everything is known about fluoridation, but sufficient material is available for one to make a decision to go ahead and fluoridate a water supply. This decision has been made by 1300 cities.

MR. KLERER: But based on what adult study, Mr. Ubell? How ridiculous can you get with this on one study?

MR. UBELL: I can get very ridiculous.

MR. KLERER: Well, you are, sir.

SENATOR MURRAY: Gentlemen, before we engage in personalities, which Town Hall has never permitted in its entire 21 years on the air, might I not ask you each if you could relate your remarks, pro or con, perhaps to one or more of the larger cities which I enumerated before as already having experimented and installed fluoridation? Has there been anything, for example, in Philadelphia or Miami or St. Louis which would shed light rather than heat upon our discussion tonight — one city perhaps about which you could disagree?

MR. UBELL: There is nothing in the published literature at this moment concerning the cities, since they have only recently — most of them recently have started fluoridating their water supply. However, some doctors have said that they have detected some cases of fluoride poisoning. In the opinion of local medical societies, these cases are not substantiated as having been caused by fluoride poisoning.

DR. ROBERT SALASIN (Atlantic City): It is presumed that one part per million in the water supply is going to be of benefit to children, provided they consume it. In other words, they've got to drink that water or else it is worthless. How much water of one part per million must a child consume daily to be of any benefit to those teeth?

MR. UBELL: I point to a preliminary study by Dr. Newman of Columbia University. He found great variation in the drinking of water by children. Children who do not drink the water do not get the benefit. Those who do are benefitted and their extent of decay is decreased by at least 60 per cent compared to Kingston.

MR. KLERER: Depending on which report you believe, Mr. Ubell.

MR. UBELL: I believe the carefully worked out studies of the State Department of Health.

SENATOR MURRAY: Regardless of the report on that, gentlemen, I'm sure the parents in the audience will agree that it is easier to get the children to drink the water than to bathe in it. Luckily you don't have to immerse them to get the benefit.

DR. JACOB REESE (West New York): My ten-year-old daughter has a perfect set of teeth after the application of fluoride at the age of four. Wouldn't the direct application do away with the present controversy of putting fluoride into water?

MR. UBELL: It seems to be a practical impossibility to get parents to take their children to dentists and have it done. It is expensive. Dentists do charges fees for each application. I'm glad to hear your daughter has a perfect set of teeth.

DR. SAUL: Mr. Klerer, more than 200 scientific, health and service organizations are for fluoridation. Can you name one single group of a national stature that is against fluoridation?

SENATOR MURRAY: He is following you around.

MR. KLERER: That is one of the "tragic," one of the horrible things about this, that the leading medical and dental associations have lent their name to such an absolutely worthless and unsubstantiated study without adequate investigation on their own; a study contradicted by data available to all, which requires the slightest effort in finding out what is available.

DR. VINCENT BUTLER, JR. (Jersey City): You seem to imply that fluoridation may have serious latent toxic effects on organs other than teeth. Is there any evidence that areas which have a naturally very high fluoride content in their water have a higher incidence of death or anything which may be recognized as chronic fluoride intoxication? I should think such towns as Bauxite, Arkansas, with their naturally high fluoride content of 16 parts per million, might be hot-beds of fluoride intoxication, if such is the case.

MR. KLERER: That's a very good question. The use of mortality statistics and medical studies is not proof of anything. For instance, in Newburgh, New York there was in the space of two years, from 1948 to 1950, a 60 per cent increase in death from cancer. I don't think that proves anything.

However, there have been some studies done of high fluoride areas; for instance, the study in Bartlett, Texas, which was mentioned; but what was mentioned was only the conclusions from the published study. There was an unpublished study which people don't hear about, a study which was cited in the National Research Council document. In the unpublished study they found that in this high fluoride area, besides a high incidence of mottled enameled teeth and increased bone density in the spine and pelvis, there was also an abnormal amount of hypertrophic changes in the spine and pelvis, ventricular opacities of the eye, and blotching of the finger nails. The authors of the unpublished study recommended further investigation. The authors of the published study, by some of the same men, do not see the need of further investigation. I find this strange. You figure out the answer.

MR. UBELL: Let me cite the very extensive mortality studies done on the population of two million in the 16 fluoridated and unfluoridated cities, in which it was shown that the major causes of death from cancer, heart disease and others were not affected by the presence or absence of fluoride.

DR. NATHAN PLAVIN (North Bergen): How will fluoridation affect the commercial water companies?

MR. UBELL: You mean will it cost them more money? I think it will cost them more money since they have to buy equipment and materials.

DR. PLAVIN: Are they opposed to this?

MR. UBELL: I haven't heard any official announcement that the commercial water companies are opposed to this, except in the case that it might mean more trouble to them. Unless Mr. Klerer has heard something.

MR. KLERER: Well, I know there are all sorts of difficulties, but since this is not a prime question I will let it go.

DR. R. WINFIELD BETTS (Medford): The homeopathic school of medicine used to attribute great systemic effects to attenuated drugs which were much less dosage than one part per million. Is there any evidence at all of any systemic effects—published reports of systemic effects from fluoridation?

MR. KLERER: Surely. It is unfortunate that most of the work that has been done on fluorisis has been published in foreign journals. The American medical profession and the Public Health Service have not been interested in following up these results. There have been studies in England made in areas which were naturally fluoridated on "recommended" levels. These studies show bone defects in adults brought up in this area. Studies in India in areas at levels of fluoride which are regarded with little concern in the United States; again there were severe bone defects. There have been studies made in the United States on industrial exposure to fluorides at very high levels, but one from these levels can guarantee that men who work in steel plants, exposed to high temperatures, who imbibe a great deal of water, or people suffering from certain specific diseases which require the drinking of large amounts of water—these people will be taking in fluorides at those levels and it is guaranteed, absolutely guaranteed from this data that after 10 to 20 years of exposure these people will show skeletal defects.

MR. UBELL: Of a non-disabling nature, I might add.

DR. ELTON W. LANCE (Rahway): Fluorine is a halogen, so is chlorine. What makes fluorine more dangerous than chlorine which is used in large amounts in nearly all water supplies?

MR. KLERER: Most of the chlorine evaporates before it gets into your mouth; in fact most of it comes out of the water tap. Fluorine is an extremely toxic poison. It doesn't take very much to kill you. A large size pinch, about a quarter of a teasponful, will prove fatal. It is one of the sodium fluorides. It is one of the most dangerous poisons known to man, and it is still poisonous at one part per million, and demonstrated by the facts gathered by the Public Health Service, which they continue to ignore, that it is dangerous, that it *does* produce objectionable mottling of the teeth, that it *does* produce adverse defects based upon their own reports. If people just read the actual reports and found out what they said, there would be no question, absolutely no question that it is a very dangerous scheme.

MR. UBELL: I would like to point out that the definition of toxicity is a very spurious one. A pinch of fluoride will kill, so will a pinch of diphtheria antitoxin. However very few physicians would hesitate to give diphtheria antitoxin to a patient, even though in large amounts this material is dangerous.

DR. DE BOW (Plainfield): What studies on animals have been made as to the effect of fluorides on other organs of the body, the bones, the lungs over long periods of time?

MR. KLERER: There have been a few studies done, unfortunately they have not been long term studies; they have been done at high levels. The mass data indicates that fluoride is extremely destructive to the soft tissues and particularly to the skeletal structure. Unfortunately, not enough work has been done on this subject.

SENATOR MURRAY: And on that note re-

gretfully, ladies and gentlemen, we must bring to a close our question period on America's Town Meeting.

May I thank our distinguished speakers for their informative and interesting discussion of why the furor over fluoridation.

Our thanks to the host for this Town Meeting, The Medical Society of New Jersey, and especially to Dr. Vincent P. Butler.

(OFF THE AIR)

QUESTION: Mr. Ubell, I find parents very cooperative when I recommend that they have their children's teeth treated. But despite the fact that the national, state and county dental associations have expressed themselves publicly in favor of it, many dentists refuse to cooperate when the parents go to the dental office. The dentist isn't recommending it. Have you any reason to explain that?

MR. UBELL: I can only explain it by the doctrine of cultural lag.

QUESTION: How about fluoride-containing dentifrices? Do you feel that they really serve the function with the fluoride being built in?

MR. UBELL: I can't comment on that. The studies that I have seen seem to me to be of inadequate nature, too short a period of time.

QUESTION: In industrial areas, is big industry opposed to fluoridation as detrimental to the use of fluorides in water in chemical and manufacturing plants?

MR. UBELL: The Board of Health of New York City sent a questionnaire out to 50 industries and received 39 replies. They found two objections. One was in the preparation of cracked ice, and the other was in the possible preparation of food concentrates. They state that both of these industries were able to handle these problems on their own. The beer industry in Milwaukee and in St. Louis found no objection in the amount of fluoride in the water as affecting the yeast in the preparation of beer.

QUESTION: Do you feel that so many of the food cultists that are on the air are doing fluoridation a lot of harm?

MR. UBELL: Food cultists are doing a lot of harm. They are doing the cause of fluoridation a lot of harm, anyway. Food cultists have a way of specifying specific diets which may not be physiologically sound.

DR. LOUIS S. WEGRYN (Union County): Have many cities in the United States given up fluoridation?

MR. UBELL: About 1300 cities have adopted fluoridation. From time to time, cities have given up fluoridation. I don't know what the score is now. I believe 30 to 40 cities have given up fluoridation.

They have given up fluoridation usually after a scare campaign which talks about fluoride being a poison, which talks about mottled teeth as if every tooth in an individual's mouth were going to fall out, and which talks about fluoride as causing all sorts of harm.

There was a study published in *The Scientific American* recently which gave some clue as to why some cities vote against fluoridation. It tied in with the degree of education of the community and other factors.

DR. WEGRYN: At Saginaw, Michigan, they gave up fluoridation because fluoride poisoning was detected by the medical society and by the medical groups of that county.

MR. UBELL: Well, those cases were gathered by Dr. George L. Waldbott. He presented 12 cases of his own, and collected 50 others by questionnaire. These were then presented to the medical society in Wayne County. They found no reason to change their endorsement of fluoridation as a measure on account of these cases.

DR. WEGRYN: Isn't it true that the American Medical Association endorsed fluoridation only *in principle?*

MR. UBELL: Yes.

DR. WEGRYN: You mentioned Bartlett, Texas. Of 116 residents there, only 11 were living as permanent residents, so how can you prove the effects of fluoridation?

MR. UBELL: I tried to point out in my original presentation that the numbers involved were small. They did serve as an indication that there were no specific abnormalities which were discovered, which could be traceable to clinical manifestations.

DR. HARROLD MURRAY: Do you think that in view of the controversy concerning the subject, a civic-lay group should support fluoridation of public water supplies?

MR. KLERER: Sir, all I ask is this: I ask that people actually inform themselves of facts which are easily available in the literature to read about it. Anybody with any sort of objective sense who reads cannot escape the conclusion that the whole thing is ludicrous, especially when you realize there are certain reports— I don't want to use the word suppressed, but there are certain reports published and then not re-published. Somehow they do not find their way into the actual published journals.

SENATOR MURRAY: I'm very sorry, but we shall have to conclude tonight's Town Meeting. I hope you enjoyed it. I think it would be fitting if we gave a final round of applause to Mr. Klerer and Mr. Ubell.

(The meeting was concluded at 10:25 p.m.)

DINNER - DANCE

Tuesday Evening, May 15, 1956

The speakers' section convened at 9:05 p.m. in the Vernon Room, Dr. Joseph P. Donnelly, Toastmaster.

The Toastmaster: Mr. President, Mrs. Butler, Members of the Woman's Auxiliary to the Medical Society, Members of the Medical Society, Guests and Friends: I do want to say a word of thanks to our hosts of the evening, the members of the Woman's Auxiliary who have made this such a wonderful party. The arrangements, as you all know, took considerable time, and this is a very fine turnout.

It gives me great pleasure at this time to introduce to you an old friend, a charter member of the Woman's Auxiliary to the Hudson County Medical Society and now the President of the Woman's Auxiliary to The Medical Society of New Jersey, Mrs. Andrew C. Ruoff. (Applause)

Mrs. Andrew C. Ruoff: Dr. and Mrs. Butler, Mr. Toastmaster, Members of The Medical Society of New Jersey, Members of the Woman's Auxiliary to the Medical Society, Mrs. Lawson, and Guests: It is my happy privilege to welcome you here this evening to the dinner-dance in honor of Dr. and Mrs. Vincent Butler. We wish to congratulate Dr. Butler at the conclusion of his year in office. We can well imagine that Dr. Butler has had a successful as well as a happy year.

At this time the Auxiliary wishes to thank the Medical Society for their ever-ready helpfulness, and personally I would like to thank the Medical Society for this beautiful corsage I am wearing, and also for the Fellowettes' pin which I shall wear with pride.

The Auxiliary stands ready at all times to assist the Medical Society. With the thought in mind that you will be interested in hearing some of the things we have been doing, we mention a few of them. This year through our county auxiliaries $3,474 was given to the American Medical Education Fund; 1,248 subscriptions were procured for *Today's Health;* 37 nurses' scholarships were given, amounting to $11,752. One county maintained a student nurses' loan fund of $300. One of our counties gave $2,200 to their medical society toward their medical scholarship fund. Our very active State Chairman of Community Health reports that health films were shown to over 12,000 people.

This was just to be an address of welcome, but I could not resist telling you about some of the work of our county auxiliaries, of which I am so proud. Our State chairmen have been doing a wonderful job also.

Dr. Butler, we wish you success in whatever you attempt, and we wish each and everyone here this evening a very pleasant evening. Thank you. (Applause)

The Toastmaster: Thank you, Mrs. Ruoff.

It is always a great privilege to come here to this party. I think that we all probably say too little to the Woman's Auxiliary for the great work they carry on. We take the Woman's Auxiliary, both collectively and individually, for granted too often, and I think it is nice that they are here tonight so that I can say for you how much we appreciate all their efforts at all times.

The next one whom it is my privilege to introduce is someone who we are very, very happy to have here tonight. He has for many years served the State Society in many capacities and certainly on the Board of Trustees for the past many years. It gives, me therefore, great pleasure to introduce to you your President, Dr. Fritts. (Applause)

This is also a very special day in the annals of The Medical Society of New Jersey. Today is Edith Madden's thirty-first birthday. (Applause) I told her sometime ago that I would buy her a double chocolate soda for her birthday, so they are delivering it over there now, and we will all sing "Happy Birthday" to Edith.

(After the song, the Toastmaster introduced the guests at the head table.)

The Toastmaster: I thought maybe at this time as the convention draws to a close I might attempt to give you sort of an eleven o'clock news summary of exactly what took place at this convention as I saw it as a bystander.

The first session of the House of Delegates was an outstanding success. Mr. Karcher, a fugitive from the New Jersey Bar Association, who acted as the Parliamentarian, retreated to the Hotel Traymore under a forced march after the first session was over.

This was a most interesting session. If any of you missed it, got down a little late, I recommend that you attend any regular meeting of the Union County Medical Society during the coming year.

To Edward Bourns, President of the Union County Medical Society, our sincere best wishes for a successful administration and an early spring, and we hope that you will enjoy

Dr. Newbury for a whole year as much as we did for the last three days. (Laughter and applause)

In the evening of that first day, Dr. Schaaf held forth at an open meeting of the Medical-Surgical Plan on Saturday evening, at which he defended the Plan against all comers. Fortunately, Dr. Schaaf has complete coverage under his new medical contract, both medical and surgical, and he escaped with a few minor lacerations and contusions which were easily repaired under the new contract, which has been taken care of in the out-patient department. He did not have to be hospitalized, and I think he did very well.

On Sunday, the Reference Committees did their work. And to those people I would like to add my word of thanks. I was not on one of them this year, but I know what a long job that is, especially this year, and I think everybody did a fine job.

It was just twenty years ago—in 1936—that I was brought to this convention for the first time by my chief, Dr. Sam Cosgrove. We arrived at this hotel just in time to see the Hudson County delegates being unseated and sent out to the boardwalk. (Laughter) From there we journeyed to Chicago. Now, twenty years later, on last Sunday we were again in a close contest. We had to go extra innings. It was a good, clean fight in the best democratic tradition. We lost a close one. And on behalf of myself and the Hudson County Medical Society I wish to offer to Dr. Hurff our heartiest congratulations and best wishes for his continuous success as a Delegate to the A.M.A. (Applause)

We of Hudson County think we have made great progress in twenty years. This time we were again beaten, but we were at least allowed to stay in the ball park after it was all over. (Laughter)

And the general session on Sunday evening, that was really something. The topic was "What's the Furor over Fluoridation? Or Why Drink Water at All?" It was a most interesting experiment and I think on a national hookup we really had something to offer. Of course, here there were some other things going on. Dr. Chester Ulmer and another unnamed volunteer each performed the three-glass test. They drank three glasses of water each. Dr. Ulmer concluded that water was a safe beverage. (Laughter) The volunteer had no comment. Dr. Ulmer is doing very well today. He is recovering. However, the other volunteer has a slight jaundice, a palpable liver which is somewhat tender and there is a possibility of an early cirrhosis. It was the conclusion at the end of the meeting that water is an excellent drink for Dr. Ulmer, but not to be recommended to the Society at large. (Laughter)

As to the final session of the House of Delegates—when the Reference Committee resolutions were brought in, the usual confusion prevailed. I think this is the only place I know where if a resolution says yes and the Reference Committee says no, then you vote yes if you wish to say no to the resolution. (Laughter) This goes on every year. It always makes for a very interesting session.

After that was over, the Parliamentarian was a basket case. He is now getting intravenous chlorpromazine and is in a cold tub. But is also doing very well. (Laughter)

So that, as I see it, was the end of our convention. I think it was a most successful one. I don't know what we proved, but we had a lot of fun. (Laughter)

You all hear about what a rugged activity the practice of medicine is and how hard it is to survive. I think we should be encouraged here tonight because we have with us some of the people who will prove to you that it is an easy way to live a long and merry life. We have in here, I'm sure many more, but I am just going to call on four whom I can see from where I'm standing.

First, Dr. William Vroom, who was the Practitioner of the Year a few years ago, and is still practicing. He is 92 years old; still taking house calls. (Applause)

We also have with us tonight Dr. George N. J. Sommer of Trenton, Dean of the American College of Surgeons in New Jersey. We are very happy to welcome him back to our convention. (Applause)

I know there are many more that I have missed, but it wouldn't be right for us from Hudson tonight not to show you a few of our old friends. First, Dr. J. Lawrence Evans, who has been practicing more than fifty years and who is still the Medical Director of the North Hudson Hospital and doing a good day's work. Dr. Larry Evans. (Applause)

And also to prove that the girls can practice medicine and still go on for many a long year — Dr. Emilie Rundlett of the Hudson County Medical Society, who has also practiced fifty years. (Applause)

Now, everybody has a few things in life which they treasure more than anything else. In Dr. Butler's case it is very easy and I would just like at this time first to introduce a lady who has made with Vince the many sacrifices which have to be made for anybody to be President of The Medical Society of New Jersey. It is a time-consuming job. It represents much time when you have to be away from home, from your office, from your profession. It also means that there is many a night when you have a date to take someone out and you

don't get home on time. I don't know of anyone who has stood up under this treatment better and happy about it at all times and has always been gracious to all of us; and it gives me great pleasure to introduce now Mrs. Vincent Butler. (Applause)

Now, I was speaking for myself, but I would think that his next treasure would be someone who has come up here over the week-end from San Antonio, Texas, Mrs. Daniel Sullivan, Dr. Butler's daughter. (Applause)

And also Dr. Vincent Butler, Jr., who is a resident in medicine at the Presbyterian Hospital with the College of Physicians and Surgeons and is soon to go into the Navy for a regular tour of duty. Dr. Vincent Butler, Jr. (Applause)

Lieutenant James David Butler is on duty with the United States Army. If you hear a jet go by, he may be here yet. We still have hopes. The convention isn't over. But I think it is only right that we should wish that he were here tonight.

And now two people who knew Vincent longer than any of us, his two sisters, Miss Helen and Miss Catherine Butler. (Applause)

I may say at this time that I have been talking to the exhibitors and, of course, some people think that this convention is run to pass resolutions and things like that. But the primary purpose of it is that the wives of the doctors can come down here and get from the exhibitors the medical care which they fail to get for themselves and their families during the year. You will get the number of registrations and things like that, those statistics from other people, but up until 4 p.m. today two and a half tons of samples were taken away by the wives of the members of this Society. (Laughter)

However, I have a warning for the medical profession that you are in for a rough year. The girls have some new favorites. It's now amphetamine and some of those do-it-yourself capsules that Fleet's Phospho-Soda® are in. At their tea yesterday, they passed a resolution showing how the Dexedrine® and Dexamyl® were to be taken. Every Wednesday afternoon, or whatever your day off is, they each take two pills at ten o'clock, pick you up at the hospital when you are finished making your rounds, you go to a show, you dance until four o'clock, come home, the alarm will ring promptly at 6 a.m. the next morning, at which time you will get two Dexedrines®; she will get some phenobarbital. (Laughter)

From all the junk they carried away other years, I think that they will get much more out of this than they have gotten out of the samples in other years. For the rest of us it's going to be a very long year, but a very happy one.

The guest of honor of the evening is Dr. Butler. I have known him since I was graduated from medical school and took a residency in the Margaret Hague Hospital. As I told you, my first introduction down here was while I was still a resident. I don't think I missed many conventions since then. That was twenty years ago. I came down not as a delegate, but just to be a member of the gang. And we had many a fine week-end and a fine convention down here.

The Hudson County Medical Society in the last forty years, as I remember it, has had five Presidents. There were others before that —Dr. Lucius Donohoe, Dr. Frederic Quigley, Dr. Joseph Londrigan, Dr. Jim Norton, and Vince. However, Dr. Donohoe at that time, while he was active, he had just resigned as a Delegate to the A.M.A. and I did not know him so well. So there was a triumvirate that started together and tonight we are honoring the last of that gang.

I think that it could be truthfully said of those people that what they attempted to do in New Jersey in medicine was guided by one thought only: what was the best medical care for all the people of New Jersey was the best plan for The Medical Society of New Jersey. There were never any other thoughts that in any way deterred them from their goal.

I came along as a sort of a bat-boy, somebody to arrange parties and so forth. I enjoyed it. They accomplished a lot. They certainly were not the front runners, but they did much to establish Blue Cross and the Medical-Surgical Plan in New Jersey on a sound basis in this state, which is the backbone of practice today, with the group hospitalization and everything else we have.

I think that in the dark hours when the National Health Insurance Law was close, as you know, they all toured the state; not only the state but the whole Atlantic seaboard. They did an excellent job. In all these things Vince more than carried his share.

He has been an outstanding doctor in New Jersey, in Jersey City. He has been a urologist, a diplomate of the American Board of Urology, a Fellow of the American College of Surgeons, Secretary of the Hudson County Medical Society for probably ten years, its President, Chairman of your Welfare Committee, Chairman of your Judicial Council, and now lastly up the ladder to be President.

He told me the other day that for the last ten years he has not missed a meeting of the Welfare Committee or of the Board of Trustees since he has been a member.

It has been an outstanding record. The

Medical Society of New Jersey has benefitted much by his labors. The people of New Jersey are getting much better medical care because of all the efforts of all the members of The Medical Society of New Jersey.

I now introduce a Past-President of your Society who will make a presentation to Vince. Dr. Lance retired just this last week from the Board of Trustees after serving for ten years. His work has been outstanding. Of all the things he did, I think that the thing, Elton, which I would treasure most— I don't know if you did—was that you were the first Presiden of the Medical-Surgical Plan of New Jersey.

It gives me great pleasure now to introduce to you Dr. Elton Lance. (Applause)

DR. ELTON W. LANCE: Mr. Toastmaster, Honored Guests, Ladies and Gentlemen: At each annual convention of The Medical Society of New Jersey there always appears a moment which, although not exactly solemn, at least to one individual here carries with it a rather indefinable connotation. It is that moment at which there occurs a change which is almost indescribable, one of those things which you can't completely explain except that it is that moment when you become, from an extremely active individual, elevated to a situation where you become a member and are privileged to join in a small area in which certan people dwell, known as the Fellows.

Now, this particular area is something which you and we of The Medical Society of New Jersey have created for them. Furthermore, these people who are chosen to become members of this select group are not members because they wish to be, but they have been chosen by you to go through that course and to assume those obligations which they are entitled to because you honor them with it.

For the past year Dr. Vincent Butler, whom I have known now for a great many years, has been a much better President than he ever was a poker player. (Laughter) Am I correct? You wouldn't know, would you, Vincent?

But at any rate, it has been now a great many years since I have known Vincent. Vincent Butler, to my personal knowledge, this year has done a tremendous job for you and for medicine in New Jersey. He has spent more hours than he can tell or his wife can tell or anyone else. No one who has not done the job can appreciate exactly what it means to spend the time away from your home, away from your office, in the interest of the doctors of New Jersey, and in the interest of the public of New Jersey, as your Toastmaster has mentioned to you.

There are certain rewards, however, that occur as a result of this transition which I have perhaps inadequately described. For instance, at lunch time from now on, with your telephone at your side on the table while you are attempting to eat, there will be no telephone call interrupting a bite out of a sandwich, from Dick Nevin at headquarters, because he will be calling someone else. And the volume of mail which used to come in to your desk will diminish and it will be a sort of a shock to you that each mail will not carry anywhere from four to seven envelopes with the heading of The Medical Society of New Jersey up in the upper left-hand corner. And you will be a little bit disappointed perhaps and wonder what is going on, but all of a sudden after two or three weeks there will be in your mail an envelope and you will seize it eagerly and tear it open and there will be a letter from Dr. Newjohn. It will be the monthly health hint, and you will get that each month, Vince. (Laughter) It's not a bad deal.

Dr. Butler, on behalf of The Medical Society of New Jersey and on behalf of the Fellows, it is an honor and a privilege for me to present to you this key which is a token of the work which you have done and the fact that you are now being honored by becoming a Fellow of The Medical Society of New Jersey. (Applause)

DR. VINCENT P. BUTLER: Dr. Lance, Mr. Toastmaster, Honored Guests, Members of The Medical Society of New Jersey, the Woman's Auxiliary, and Friends: To receive this key and be placed in the category of a Fellow, to be placed in that select circle is indeed a rare honor. I cherish it most highly and I will retain this key as a memento of that for the rest of my days. I wish to convey to The Medical Society of New Jersey, through Dr. Lance, my deep appreciation for this key as a memento of that initiation into the Fellowship of The Medical Society of New Jersey.

I would like to thank the Woman's Auxiliary for making this dinner possible. I advisedly use the phrase "making it possible." It reminds me of the time when Yogi Berra, the Yankee's catcher, who was not a very articulate individual, was given a dinner by his home folks in St. Louis honoring him for receiving the award as the most valuable player. He was reluctant to go on the dais and was more reluctant to make a speech. The committee insisted that he get up and say something. So Yogi did. He made a speech of seven words, which was why I was very particular as to how I phrased mine. Yogi said: "I thank you very much for making this dinner necessary." (Laughter)

That is not my sentiment however, but

t this time it is very difficult to express one's eelings. But there are certain reactions which ou get. One of them is the sense of gratitude hat I feel for all those members of the Medial Society who have honored me with the disinction of being their President. I would particularly say that is so of every one of the wenty-one counties, but more especially or ust a little bit more for Hudson County. I hall always remember them and their feelings owards me and the confidences which they ave placed in me.

There are many, many people over and bove that to whom I am extremely grateful, ut it would be rather difficult at this time for ne to individually express my appreciation. But I cannot let this occasion go by without lirecting it to three individuals.

Around Christmas time the office force at he Trenton State headquarters gives the President a party and at that time I learned from Mrs. Madden that this was, I thought she said, her twenty-first birthday, but I may be in error. At least, she said that her birthday fell on this same date. So I agreed that I would share this party with her. I am happy to do that in some small degree because I have felt that the aid which I have gotten from Mrs. Madden was something that I could not possibly get along without. The efficiency and the cooperation with which she operates is something that you have to see firsthand to be able to believe it possible. She has been extremely nice to me and I got thinking the other day of how nice she is and what there was about me that she should be so nice to me, but then on thinking a little bit more I came to the certain conclusion there was nothing about me particularly that she was nice to me for. She is just nice to everybody.

Mrs. Madden, would you please take a bow? And happy birthday to you. (Applause)

The Executive Officer has been a personal friend of mine for a long time and I have known of many of his talents. When The Medical Society of New Jersey sought an Executive Officer, he seemed to me ideally fitted and certainly time has not diminished in any way my estimate of his capabilities. At one time he was a professor of English and a professor of Speech. He had some experience as a medical student. He was the ideal combination of qualifications for that office. But over and above that, were certain personal features which he possessed which made him more desirable than, I think, anybody else could be. And for his innumerable acts of kindness in the smallest and in the greatest degree, the appreciation which I have for him I want to express now, and I'd like to have him take a bow—Mr. Richard Nevin, the Executive Officer of The Medical Society of New Jersey. (Applause)

And there is one other person. I don't think many people, except probably my predecessor, Dr. Lance, and some of the others who have gone through the office of President, realize what a task it is to get together a program for this convention. Mrs. Madden is the Convention Manager. The Chairman of the Convention Committee has probably already started in on the work of preparing the convention for 1957. I don't know what your idea of the convention has been this year, but to me it has been an outstanding success. To correlate all of the necessary factors, the scientific exhibits, the commercial exhibits, the programs which are to be presented, the sectional meetings, and all of the other features of it are something that takes an extreme degree of talent and efficiency. That has been done, and I here, as I have told him privately, wish to pay publicly my regards to him for his efforts.

I would like Dr. Jerome Kaufman to stand and take a bow—the Chairman of the Convention Committee. (Applause)

And there are just a few other feelings that come to me as I stand here in what is my swansong as the President of The Medical Society of New Jersey, and that is one of really I might call thanksgiving. I have been extremely thankful to have been blessed with fine friends, a wonderful family and good health. And apropos of the good health, I am quite sure that the woman who has tolerated me all of these years is the most surprised person in the world that I am alive, because I have had this predicted daily that I was slowly killing myself. I don't know whether I am any nearer that point, but it certainly has not had what I'm sure she thought was going to be the dire result upon my health.

I must also pay tribute to her for her patience and indulgence with what I suppose to her seemed to be a lot of unnecessary antics traveling around the state. I am reminded in that respect of a story that was told to me by a clergyman who was at the fiftieth wedding anniversary of some friends of his parents. He had known these people for a long time. After having been married fifty years, they were celebrating. The old man was a crotchety old fellow; not that I like to put myself in that category, but for the benefit of the story maybe I might be. And this clergyman said to the wife: "How has it been through all these years that you have been able to live with that man. Didn't you ever at any time think of getting rid of him, divorcing him, getting rid of him in some way?" And she said: "Father, many, many times have I thought of getting rid of him. Getting rid of him by

divorce, never. Murder, often." (Laughter) So I presume maybe that is the way Mrs. Butler has felt. But she hasn't executed the murder.

At this time I also have one other feeling and that is a degree of regret that the people to whom Dr. Donnelly referred, some of my old and very intimate friends, are not here to see me receive this honor. I'm sure that they would be with me if they could. In spirit I'm sure that they *are* here.

So now I wish to thank everybody for all their cooperation and nice things they have done and said about me. And to my predecessor, Dr. Lance, I would say: Push over, Elton, and make room for me on that bench. And to my successor, Dr. Fritts, continued good health and a happy and successful year. (Applause)

THE TOASTMASTER: Well, I was particularly gald to hear Dr. Butler thank Dr. Kaufman for the excellent job he did at the convention. After all, we might as well claim Essex, too. It's a neighboring county. And while we do have some differences of opinion at times, they are not nearly as marked as the story my grandfather told years ago about the Belleville Turnpike. It crosses the river where Hudson and Essex adjoin. There were two families living there. The children played together. The little girl lived on the Essex side and the boy on the other side. They used to row back and forth. This warm summer day they decided to go in for a swim and they just took off their clothes and dove in and when they came back up on the dock he got a look at this lassie in her birthday suit and said: "I never knew there was that much difference between Hudson and Essex." (Laughter) And actually it really is only geographical, and not even that.

For many years we of New Jersey have been looking forward to the day when we would have a medical school. We are particularly happy at this convention that the year is now upon us and that the new medical school will open in the fall. We in Hudson County were maybe a little closer to it at the start. But I'm sure that everybody will be close to it when it does start. We are particularly happy about one thing more than anything else, and that is about the man who is to be the new Dean of the medical school. You all know, as I do, from past history something of his record.

He was born in Illinois, graduated from the University of Oklahoma Medical School. He was a resident in medicine at Peter Bent Brigham Hospital in Boston and served as an instructor in both medicine and pathology at the Harvard Medical School. He then went to the University of Michigan, at Ann Arbor, where he was the Assistant Professor of Medicine and distinguished himself for many years as an internist. At that time he was called to become the Professor of Medicine at Temple University in Philadelphia and shortly after that became the Dean of the Temple University Medical School. He was there in the years that Temple built itself into one of the great medical schools in the East.

At that time some difficulties developed at Hahnemann. He was asked to go to Hahnemann to straighten out a very difficult situation. This he did. He got the school back in working order. When it was known that the new medical school was to be started here in New Jersey, he was one of the candidates most sought after by the President of Seton Hall to become the new Dean.

We had all known of him before for his work as a splendid internist, for his work as a medical educator, where he was held in very high regard by the Deans' Committee and by all the deans of all the medical schools in the United States. But it was only after he came to Jersey City that we realized for the first time, that here was not only a man who was a great doctor, a great administrator, but most of all was one of the most warm-hearted and friendliest of persons. He was most interested in the new medical students and in the picking of his staff for the new school.

We in Jersey City are happy about having a medical school. The thing we are most happy about is that Dr. Charles Brown is the new Dean of the medical school.

It gives me great pleasure now to introduce to you the Dean of the Medical College of Seton Hall University—Dr. Charles L. Brown. (Applause)

DR. CHARLES L. BROWN: Mr. Toastmaster, Dr. and Mrs. Butler, Dr. Fritts, Ladies and Gentlemen: I want to express my pride in being here with The Medical Society of New Jersey. I wish to recognize the honor which you have accorded me in inviting me here this evening. I would also express my appreciation in being allowed to share in the opportunity to pay tribute to Dr. and Mrs. Butler on this memorable occasion.

The subject of my presentation is a rather heavy one for such a delightful social occasion as this. I wish that it might be a little more subject to levity, but I think it would be wrong to deprive our thoughts at this time of any less serious thinking and discussion.

Medical education essentially may be divided into three parts. The first stage is that of undergraduate medical education. This is the main function of a medical school. The second stage is one of supervised clinical seasoning, if you please, which, of course, includes the internship and residency years. The third stage is one that lasts for the rest of one's pro-

fessional life; namely, the self-continuation of education. That becomes pretty largely a personal variation in accordance with the interests and the opportunities of the individual physician. I shall restrict my remarks largely to the upper graduate medical education rather than to any of the other phases.

There is a change in the practice of medicine today as compared with many years gone by. That change has been one of expansion and one of increasing the scope of coverage and one that has included comprehensiveness. The expansion and comprehensiveness of practice has been recognized and has become a part of the physician, young or old, after he has been out of medical school.

It now behooves the medical school to recognize the changes not only in demands, but in the actual operation and practice of medicine. The practice of medicine today is so comprehensive that one can hardly visualize the limits. As we select students, we should have seriously in mind the application of medicine to the public at large and in particular to the individual who has the need of care for illness. We hope that most of the students who graduate from this new school will actually practice medicine in the area that we commonly refer to as general practice.

General practice is not limited to rural communities. The need for people to do general practice is great in many of the urban and suburban areas. General practice should be attended to by the best prepared physicians that we can produce. In general practice so often there is not the ready help of an expert right at hand. The general practitioner should be prepared, he should be trained, if it were possible, even more extensively than the specialist.

Many physicians today will go into industrial practice, will go into public health service of some fashion or other; some will do research, and many will do their time in military medicine; and a small group will continue in military medicine as a career.

I would hope that we could do a good job in giving students the basic start. I would hope that we could imbue in them the ambition, the curiosity and the intensity of purpose to continue their education to the utmost in those areas which they themselves may choose and I hope will be limited only by their ambition and opportunity. We hope that we can teach them to grasp opportunity and make the most of it for the good of the profession and for the good of the people that the profession serves.

So there has been established a new school in New Jersey: the Seton Hall College of Medicine and Dentistry. I shall refer to my dental colleagues by saying that the setting up of these two schools in combination — and there is a Dean of the Dental School, Dr. Merritt Maxwell, who is a wonderful colleague to work with—there has been thought advisable to have these two schools in combination perhaps for the basic purpose of bringing the dental and medical professions closer together as we actually live in our day's work in training these youngsters, and, of course, to take advantage of any economic features, such as using the same faculty particularly in the first two years for both medical and dental students.

The administration of Seton Hall University, through its President, Monsignor McNulty, has established this medical school with one purpose in mind: to serve the medical profession and the people of New Jersey, and therefore share in the responsibility of this state to contribute to this needed enlargement of the pool of physicians not only to care for the people of this state but also to contribute to the health and welfare of this entire nation.

As I was engaged to become the Dean of this school, the only direction that I had from Monsignor McNulty was to make it the finest medical school possible; that I should have the opportunity of recruiting faculty and selecting students without reference or without restriction to race, color or creed. That has been carried out to the letter of that direction.

Monsignor McNulty said: "We would like to develop a medical school of which we can be proud, both professionally and physically." They are dedicated to doing just that. Both publicly and privately it has been agreed that this is to be our contribution to the health and welfare of the nation and in particular as it can be applied to New Jersey, both to the profession and the public of this state.

That is a real challenge to me. This is one of the main reasons I have accepted this position. I will need your help and advice. I can assure you that I will need the assistance of those who are wiser than I among you.

In establishing a school of this type there are several basic things that must be done. The Department of Education of the State of New Jersey must approve the name of the college. It also must consider the licensure of the college to operate and grant the degree of doctor of medicine. Our own State Board of Medical Examiners must also consider the details in establishing such a school. It is necessary that we have their approval in order to get a license to operate.

There are two national accrediting agencies: the Association of American Medical Colleges and the Council on Medical Education of the American Medical Association. These two accrediting agencies have spent considerable time with us. They know our plans and have given

us much encouragement. All of these things have been done.

The State Board of Medical Examiners of New Jersey have been made familiar with plans for development of the school. I am pleased to have had their very cordial consideration of us.

Now, then, I would like to have The Medical Society of New Jersey remain in close touch with our plans and with our development. I am new in the state and hardly know the scope of organization. Do you have a standing committee that one might refer to as the Educational Committee? I would be hopeful that the Officers, Trustees, or the House of Delegates would officially establish a liaison committee that could be advisory to us in this development. As the school is developed, we hope that you will consider this *your* school. It is a school of New Jersey to serve its people and the profession. It would be indeed good to have the guidance of this state organization to know what is going on and to advise us. Our graduates will need to have put into their educational program those things that you men and women know about out on the firing lines and in general practice. I am hopeful that we may have such liaison with The Medical Society of New Jersey.

As far as the teaching is concerned, the current trend is to have the student learn to do by doing. A medical school has about thirty departments ordinarily, if one considers the sub-specialties as separate departments. However, twelve departments usually carry the over-all load of the educational program. These are divided into the first two years and the last two years. The first two years need six departments: anatomy, physiology, biochemistry, Pharmacology, bacteriology, and pathology. The last two years include: surgery and its sub-specialties; pediatrics; obstetrics and gynecology. The tendency over the country is to combine obstetrics and gynecology. Dr. Samuel Cosgrove was good enough not long ago to make a survey of all the medical schools in this country and found that 60 out of 80 schools combine these two departments. As one gets from basic, pre-clinical sciences over into clinical medicine, the trend is to start to teach clinical medicine earlier than in former medical school curricula; namely toward the tail end of the second year. We expect to put this into our program.

For example, in the medical school at the time many of us here attended, the only clinical work that was done in the second year was physical diagnosis and history-taking. With regard to physical diagnosis it is our thought that there is no reason why this subject should be imposed only on the Department of Medicine. Indeed, physical diagnosis should be taught by every segment of the faculty. Thus, I think it right for ophthalmologists to teach our students how to use the ophthalmoscope in examining eyes. I think it is proper that the surgeon teach our students how to examine an abdomen in which there is suspected to be surgical disease. I think it is proper that the obstetrician teach our students how to examine the abdomen of a pregnant woman. In days gone by these were taught in the Department of Medicine.

I am beginning to think of the needs of a larger faculty. When one brings into effect these modern plans of teaching, it means that you need manpower to do it; you need more people. That is one of the reasons that medical education is becoming more expensive.

In the junior and senior years we plan to use the complete clinical clerkship plan. We expect to do away with most of the formal lectures. The teaching will largely be done in small groups of seminars and conferences and the student will largely spend his day on the ward or in the out-patient department with his teachers, with the patients assigned to him, and a laboratory. He will be actually learning to practice at a time that he is still a medical student, under the supervision of teachers. Under such a scheme, we need more teachers than just someone to come in and give a lecture twice a week.

I think it is likely that we will have a faculy in the neighborhood of four to five hundred teachers. Forty-five to fifty of these will be in the pre-clinical departments. The rest will be in our clinical faculty. We shall draw upon our local people to help us. We hope they will be willing.

The Staff of the Medical Center will essentially become the core of our faculty. We are hopeful that those in the area who can find time to help us, even though they are not on the Medical Center staff, will also find it possible to join our faculty.

As we get into the clinical years, this becomes a highly cooperative affair with the municipal government of Jersey City. This has been effectively done in many other cities. It makes it possible for the medical school to have what is direly needed in the teaching of medicine: hospital or medical center facilities such as Jersey City provides.

The medical center setup is probably the ideal one for the teaching of undergraduate or post-graduate medicine. Many medical schools with only a single hospital have enlarged into the formation of medical centers in which other hospitals become involved in the teaching. That has been the progressive trend. It is our expectation, of course, to take and incorporate those features in this new school.

There are about 15,000 college students in this country each year who would like to study medicine. All of the medical schools of the country—there are now 80 plus four in development—the ones that are now in existence, have a total capacity of 7500 students—of the 7500 entering medical school, at the end of four year only about 6500 will graduate. The attrition rate of all of the schools in this country is somewhere between 500 and 1,000.

Think of the heartaches that go into those who are not able to continue! If only our admissions committees were able to select students who could go the whole distance! It seems a shame when so much time and money and effort have gone into the selection of students, that we should have that attrition. I'm sure we are not going to do better than any other school, but by the selection of students we are going to try to avoid the loss of them after they once have been admitted to the medical school.

There are always a few students — occasionally one will decide he does not want to study medicine after he has already come to medical school. Occasionally one or two out of a class will become so ill of some disease that they cannot continue, or at least there is temporary dropping out. And then, of course, there are the few that fail, who cannot go on.

So that of 7500 taken in each year, about 6500 graduate. That is the output of the medical schools of this country each year.

If one bears in mind the many needs for the doctor because of this expansiveness and enlargement of the practice of medicine, realizing the number of doctors who retire or die each year, you can see there is a great need for medical schools and there would be more if they were not so expensive to establish and to run.

The four schools now in development include the University of Miami which is graduating their first class this year. The University of Florida starts this fall, as we do. The Albert Einstein Medical School in the Bronx is a year ahead of us. But the combined enrollment of these four new developing schools is less than 500.

How many New Jersey residents want to enter medical school each year? I do not know. I suspect that there are several hundred. We have 350 applications this year for admission to our school this fall. There were 830 applications which were filed with us, 350 of which were New Jersey residents. I pointed out to you the freedom and lack of restriction regarding race, color and creed. We are showing a preference for New Jersey residents. I think we should. That is the only preference that I know is being given in the selection of our students.

The maximum number of students that we can take in medicine is 80. When all four classes are present, the maximum will be 320. We will graduate approximately 80 each year. It will cost about $1,250,000 to run the medical school every year. The average of cost per student over the country is about $2,500. That is a lot of money for one student. It seems likely that our cost will be in the neighborhood of $2,500, perhaps as high as $3,000 per student. It will be a little higher until the school is actually running and we have a complete enrollment.

The tuition is $950. The difference between $950 and, shall we say, $2,500 or $3,000 is the amount of money that has to be provided to run this school; that is, that amount multiplied by the number of students. Again that is one of the reasons it is such a problem to establish and to operate a medical school.

To establish the school and get it under way, Seton Hall University has leased a building for 50 years at a rental of $275,000 a year. That is the Medical and Dental School Building. The cost of demolition of the inside of the building and reconstructing it, remodeling it will be between $800,000 and $900,000. Seton Hall is paying all of this. This is not at any expense to Jersey City.

The laboratory furniture, tables, fixed equipment, *et cetera* for the student and research laboratories will cost well over $200,000, perhaps closer to a quarter of a million dollars. Thus, there will be considerably over a million dollars, perhaps closer to a million and a half in getting ready to put the show on the road.

Seton Hall has undertaken this sizeable and additional educational load with the complete dedication to making this one of the best medical schools that can be made. I hope that I have the vision and the strength to do what is expected of me. I am also hopeful that The Medical Society of New Jersey will furnish a liaison which will bring to you and keep you informed of our thoughts, of our developments, our planning, because I can honestly say it is with the thought that this school can make a great contribution to the medical profession and the people of this state that we are doing what we are.

Thank you so much. (Applause)

THE TOASTMASTER: In behalf of all the members of the Medical Society and their guests, I wish publicly to thank Dr. Brown for this excellent discourse tonight on the new medical school. I think he has answered many of the questions that a lot of us wished to ask. I only hope that if he was twenty years in Pennsylvania, he will be many more in New Jersey running this project for us.

TRANSACTIONS OF

THE WOMAN'S AUXILIARY

TO

THE MEDICAL SOCIETY OF NEW JERSEY

Twenty-ninth Annual Meeting

The twenty-ninth annual meeting of the Woman's Auxiliary to The Medical Society of New Jersey was declared in session by the President, Mrs. Andrew C. Ruoff, Sr., on May 15, 1956, at Haddon Hall, Atlantic City. Invocation was given by the Rev. Richard L. Robinson of the First Baptist Church, Atlantic City.

The pledge of loyalty was repeated by all present.

Mrs. Irving C. Shavelson, President of the Woman's Auxiliary to the Medical Society of Atlantic County gave the speech of welcome. Response was given by Mrs. Bertram J. L. Sauerbrunn, President-elect of the State Auxiliary. On motion of Mrs. Harry Subin, Convention Chairman, the convention program as planned, was accepted.

Mrs. Mason G. Lawson, President, Woman's Auxiliary to the American Medical Association, was then introduced.

The roll was called by the Recording Secretary, Mrs. D. Leo Haggerty.

Minutes of the twenty-eighth annual session were read by the Recording Secretary. Since the minutes were approved by the reading committee, they were accepted.

Mrs. David B. Allman, Parliamentarian, read the convention rules. On her motion, these were adopted for the 1956 annual meeting.

The Credentials Chairman, Mrs. Samuel L. Winn, reported that 275 women had registered.

The Memorial Service for departed members was conducted by Mrs. Oswald R. Carlander, Fellowette.

Mrs. Thomas DeCecio, Treasurer, reported a balance of $4,501.27. Mrs. Haggerty read the report of the auditor, Mr. Willard Roberts, of Trenton. These reports were accepted for filing.

Mrs. John C. Voss, First Vice-President, took the chair for the reading of the president's report. On motion of Mrs. Rauschenbach, the president's report was accepted with thanks.

Reports of county presidents and state chairmen were printed in the Annual Reports Book. The reports were accepted as printed.

Reports were given by the following state officers:

President-Elect—Mrs. Bertram J. L. Sauerbrunn
First Vice-President—Mrs. John C. Voss
Second Vice-President—Mrs. A. Guy Campo
Recording Secretary—Mrs. D. Leo Haggerty

The following state committee reports were given:

A.M.E.F.—Mrs. Frank S. Forte
Archives—Mrs. William E. Dodd
Bulletin—Mrs. J. Howard Hornberger
Chronically Ill—Mrs. Joseph Judd, Jr.
Community Health—Mrs. John F. Johnson
Civil Defense—Mrs. Henry D. Chieffo
Conference—Mrs. Bertram J. L. Sauerbrunn
Finance—Mrs. Robert B. Walker
Historian—Mrs. George Knauer, Sr.
Hospitality—Mrs. George A. Corio
Hub—Mrs. Paul Aszody
Legislation—Mrs. Ralph K. Bush
Medical History—Mrs. Samuel H. Jessurun
Mental Health—Mrs. George Scheibal
News-Note—Mrs. John F. Kustrup
Nurse Recruitment—Mrs. Ben W. Berner
Organization & Membership—Mrs. A. Guy Campo
Parliamentarian—Mrs. David B. Allman
Program—Mrs. John C. Voss
Revisions—Mrs. Richard J. McDonald
Today's Health—Mrs. Edgar W. Weigel
Widows & Orphans—Mrs. William J. Gleeson

Mrs. Ruoff introduced two of the State Directors, Mrs. Richard H. Demarce and Mrs. Lloyd A. Hamilton.

The following county presidents' reports were given:

Atlantic—Mrs. Irving C. Shavelson
Bergen—Mrs. George O. Rowohlt
Burlington—Mrs. Ralph H. Van Meter
Camden—Mrs. A. M. K. Maldeis
Cape May—Mrs. Samuel J. Mazzotta
Cumberland—Mrs. H. S. Branin
Essex—Mrs. Ralph R. Antorino
Gloucester—Mrs. Robert C. Puff
Hudson—Mrs. Paul J. Miranti
Hunterdon—Mrs. Lloyd A. Hamilton
Mercer—Mrs. Sydney G. Fine
Monmouth—Mrs. John A. Tilley
Passaic—Mrs. Elias J. Hatem
Salem—Mrs. David G. Neander
Somerset—Mrs. Harold N. Wender
Union—Mrs. Walter S. Booth

Mrs. Ruoff then introduced Mrs. Thomas H. McGuire, President-Elect, Woman's Auxiliary to the Medical Society of Delaware.

On motion by Mrs. Sauerbrunn, the Secretary was directed to send a telegram to Senator H. Alexander Smith and Senator Clifford B. Case opposing the disability clause in the Social Security Amendment H. R. 7225.

Mrs. Ruoff called for nominations for the nominating committee. The following were elected to serve on that committee.

Mrs. Andrew C. Ruoff, Sr., Chairman — Hudson County
Mrs. Gorman Jaffe—Ocean County
Mrs. Maurice Ré—Bergen County
Mrs. George Parell—Essex County
Mrs. Edward Cicione—Burlington County

Mrs. Paul E. Rauschenbach presented the following report of the Nominating Committee:

President-Elect—Mrs. John C. Voss—Burlington County
First Vice-President—Mrs. A. Guy Campo — Gloucester County
Second Vice-President—Mrs. D. Leo Haggerty—Mercer County
Recording Secretary—Mrs. John J. Torppey — Essex County
Treasurer—Mrs. Thomas DeCecio — Bergen County
Directors for 1956-59—Mrs. Richard H. Demaree —Monmouth County; Mrs. Gorman Jaffe—Ocean County

The chair called for nominations from the floor; none were made. Upon motion by Mrs. Epler, seconded by Mrs. Sauerbrunn, and unanimously carried, the candidates proposed by the committee were elected to the offices indicated.

Upon motion by Mrs. Glazier, seconded by Mrs. Rauschenbach and unanimously carried, the following courtesy resolutions were adopted:

THANKS TO OUR PRESIDENT

Whereas, Our President, Mrs. Andrew C. Ruoff, Sr., has served the Woman's Auxiliary to The Medical Society well; and

Whereas, Her genial manner and devotion to her duties has promoted a most cordial relationship among the members; therefore be it

Resolved, That the Woman's Auxiliary to The Medical Society at its Twenty-ninth Annual Meeting express to our retiring President, Mrs. Andrew C. Ruoff, Sr., the grateful thanks of the members.

APPRECIATION TO DR. BUTLER

Whereas, Dr. Vincent P. Butler, President of the Medical Society, has advised and assisted the Woman's Auxiliary, and

Whereas, His friendliness has encouraged every officer and member who has had the privilege of knowing him, therefore be it

Resolved, That the Woman's Auxiliary to The Medical Society of New Jersey at its Twenty-ninth Annual Meeting express to Dr. Vincent P. Butler, the sincere appreciation of the Woman's Auxiliary.

THANKS TO DR. FRITTS

Whereas, Dr. Lewis C. Fritts, Advisor to the Woman's Auxiliary, has given unstintingly of his time and efforts in promoting the plans and programs of the Auxiliary, therefore be it

Resolved, That the Woman's Auxiliary at its Twenty-ninth Annual Meeting, express its thanks and sincere appreciation for these courtesies to Dr. Lewis C. Fritts, Advisor to the Woman's Auxiliary to The Medical Society of New Jersey.

THANKS TO MRS. EDITH MADDEN

Whereas, The Woman's Auxiliary to the Medical Society is deeply grateful to Mrs. Edith Madden, Medical Society Administrative Secretary, for the many services rendered during the past year; and

Whereas, She has given so much of her time and effort to smoothing out the mechanical details of the administration of our Woman's Auxiliary to the Medical Society; therefore be it

Resolved, That the Woman's Auxiliary to The Medical Society of New Jersey at its Twenty-ninth Annual Meeting, express sincere appreciation and our many thanks.

APPRECIATION TO MRS. SUBIN AND COMMITTEE

Whereas, Mrs. Subin and her committee have worked so diligently on behalf of the Woman's Auxiliary to The Medical Society of New Jersey and

Whereas, Mrs. Subin and her committee, always having the best interests of the Auxiliary Members in mind, has planned so efficiently as to our enjoyment and comfort, therefore be it

Resolved, That the Woman's Auxiliary at its Twenty-ninth Annual Meeting, express sincere appreciation and heartfelt thanks to Mrs. Subin and her committee for their untiring efforts on behalf of the Auxiliary.

APPRECIATION TO MISS LORENZO

Whereas, Miss Carmela Lorenzo has done yeoman service in compiling our records and has always been ready to help officers and chairmen when the need arose, therefore be it

Resolved, That the Woman's Auxiliary to The Medical Society of New Jersey, express sincere appreciation and thanks to Miss Lorenzo at its Twenty-ninth Annual Meeting.

APPRECIATION TO HALDON HALL

Whereas, The Woman's Auxiliary to The Medical Society of New Jersey in convention assembled May 1956, wish to convey to the Management and Staff of Haddon Hall, their cognizance of the many courtesies extended, therefore be it

Resolved, That the Woman's Auxiliary express thanks and appreciation to all those who have extended these courtesies and helped to make this convention a memorable one.

Mrs. Winn, Credentials Chairman, reported a final registration count of 378.

Mrs. Ruoff appointed a reading committee for the minutes of the annual session. They are as follows: Mrs. Cottone, Mrs. Kustrup, and Mrs. Corson.

Mrs. Rauschenbach conducted the ceremony of the installation of officers. Mrs. Ruoff, retiring president, turned the gavel over to Mrs. Sauerbrunn, who delivered a short speech of acceptance.

The 29th Annual Session of the Woman's Auxiliary to The Medical Society of New Jersey was declared adjourned.

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Albert B. Kump (1957) ..... Bridgeton
Elton W. Lance (1957) ..... Rahway
Jesse McCall (1956) ..... Newton
Herschel Pettit (1956) ..... Ocean City
John H. Rowland (1956) ..... New Brunswick

1956-1957 COMMITTEE CHAIRMEN

Annual Meeting ..... Jerome G. Kaufman, Newark
Cancer Control ..... George P. Koeck, Newark
Chronically Ill ..... William H. Hahn, Newark
Emergency Medical Service, Civil Defense ..... R. Winfield Betts, Medford
Finance and Budget ..... David B. Allman, Atlantic City
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Honorary Membership ..... Aldrich C. Crowe, Ocean City
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Routine Health Examination ..... Robert E. Verdon, Cliffside Park
School Health ..... Neil Castaldo, Cranford
Scientific Exhibit ..... William W. Hersohn, Atlantic City
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individualized *use of rauwolfia in the management of hypertension*

Rauval®
(Rauwolfia Serpentina)



contains all the therapeutically active alkaloids of whole powdered *Rauwolfia serpentina* (double-assayed) to provide a unique balance of hypotensive and sedative benefits.[1] Bottles of 100 and 1000 sugar-coated tablets: 50-mg. red and 100-mg. pink tablets.

Rauprote
(Rauwolfia Serpentina and Protoveratrines A and B Combined) Trademark



clinically proved combination for moderate or severe hypertension. Each agent appears to potentiate the other's hypotensive activity and produce beneficial vasodilatation, tranquilization, and sedative responses with a minimum of risk.[2] Bottles of 100 and 1000 tablets, each containing 50 mg. *Rauwolfia serpentina* and 0.2 mg. protoveratrines A and B.

Serpate
(Reserpine) Trademark



presents the principal crystalline alkaloid of rauwolfia...reduces the "psychic magnitude" of everyday stresses in patients with mild or labile hypertension.[3] Bottles of 100, 500, and 1000 scored tablets: 0.1-mg. white, 0.25-mg. yellow, and 1.0-mg. orange tablets.

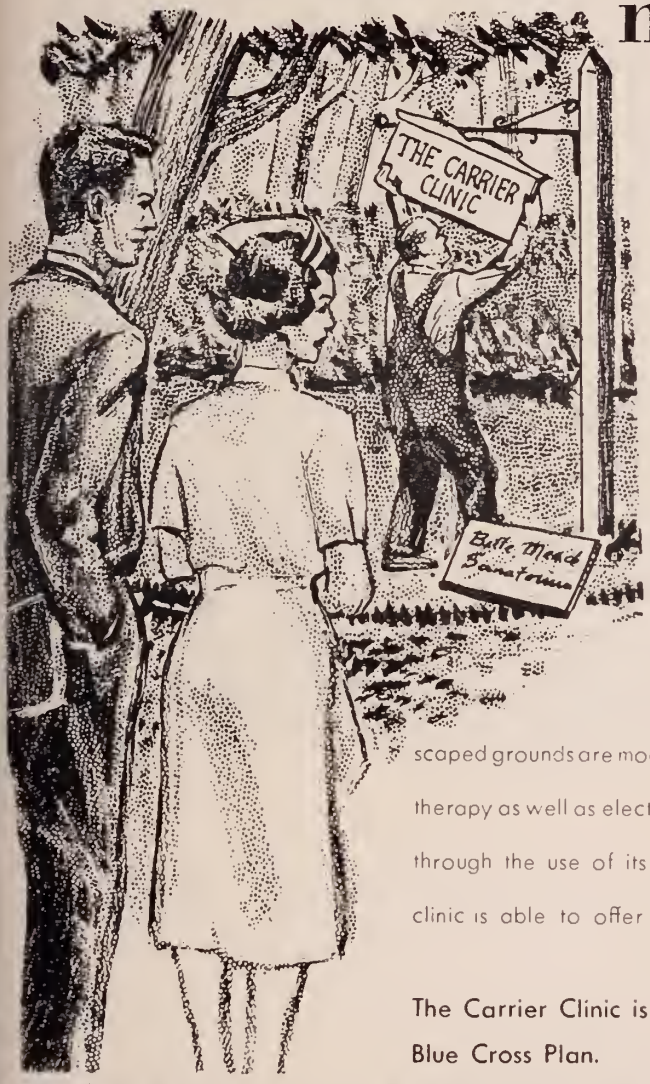
1. Wilkins, R. W.: Ann. New York Acad. Sc. 59:36, 1954. 2. Meilman, E.: Circulation 13:596, 1956. 3. Wolferth, C. C.: Pennsylvania M. J. 59:327, 1956.

specialists in rauwolfia preparations

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The long-established Belle Mead Sanatorium, located near Princeton, New Jersey, is now called "The Carrier Clinic" The Carrier Clinic will, of course, carry on the traditional purpose of Belle Mead to apply the most advanced psychiatric techniques to the care of the emotionally disturbed. And too, the clinic now has added accommodations for the arteriosclerotic and the senile

Resting on 350 acres of beautifully landscaped grounds are modern hospital facilities providing intensive psychotherapy as well as electro-shock, deep insulin and chemo-therapies. Also through the use of its occupational and recreational equipment the clinic is able to offer its patients arts and crafts, music and athletics.

The Carrier Clinic is a contracting hospital of the New Jersey Blue Cross Plan.

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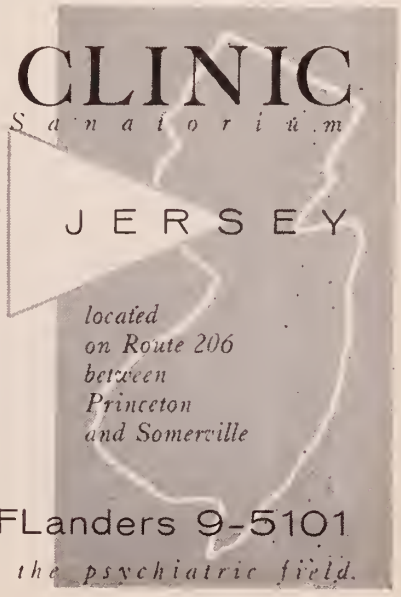
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(phenylbutazone GEIGY)

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relieves pain

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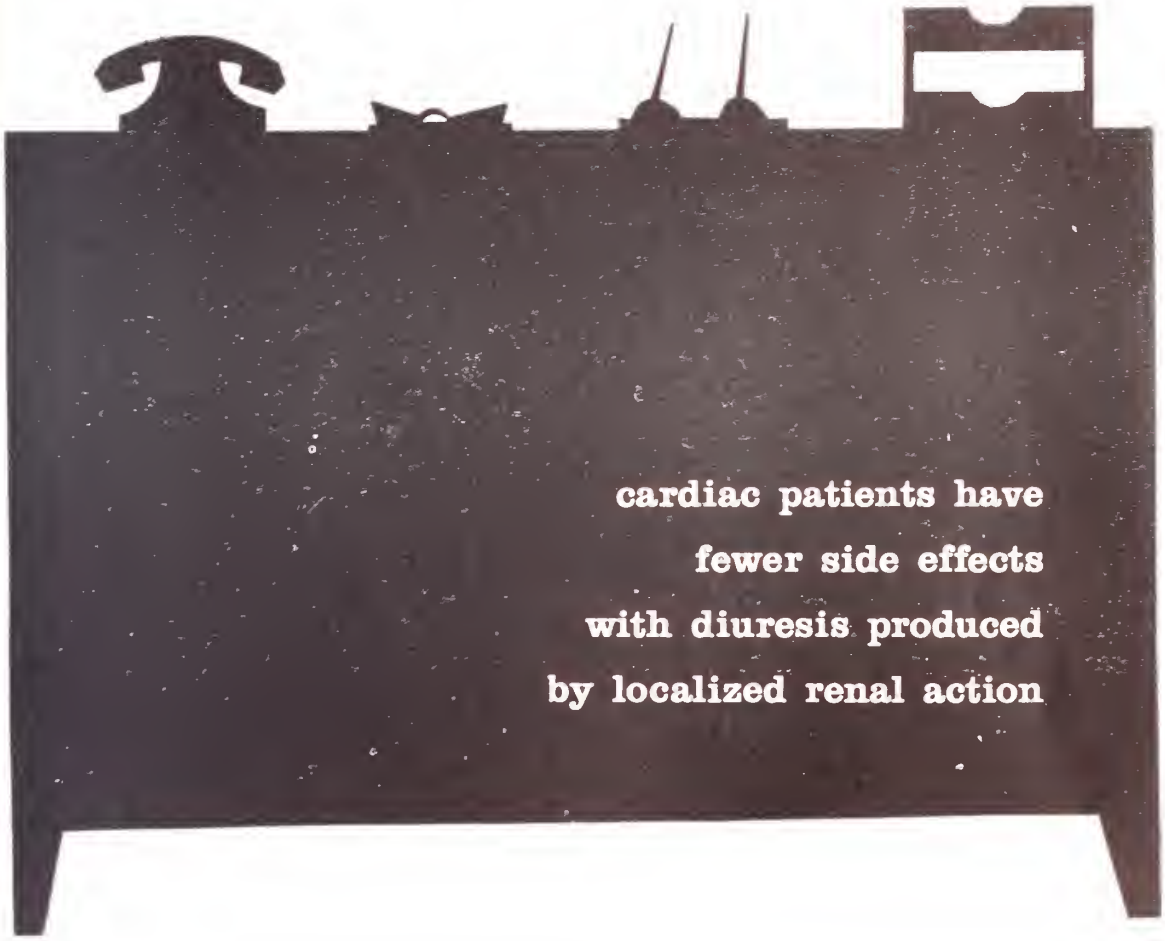
resolves inflammation

BUTAZOLIDIN being a potent therapeutic agent, physicians unfamiliar with its use are urged to send for literature before prescribing it.

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When acidosis is the diuretic mechanism, as with the carbonic anhydrase inhibitors and acidifying salts, widespread effects on many organs can be anticipated. In contrast, the dependable diuresis produced by the organomercurials—resulting from enzyme inhibition localized in the kidney—avoids these extrarenal effects.

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BRAND OF CHLORMERODRIN (18.3 MG. OF 3-CHLOROMERCURI-2-METHOXY PROPYL UREA EQUIVALENT TO 5 MG. OF NON-IONIC MERCURY IN EACH TABLET)

a standard for initial control of severe failure

MERCUHYDRIN® SODIUM

BRAND OF MERALLURIDE INJECTION

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NEW

ATARAXOID is a unique, new combination of STERANE and ATARAX, which now permits simultaneous symptomatic control and reduction of attendant anxiety and apprehension in rheumatoid arthritis and other indications.

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ATARAXOID exerts the anti-rheumatic, anti-inflammatory activity of STERANE distinctly superior to previous steroids, effective in radically reduced dosage, and with minimal disturbance of electrolyte and fluid metabolism.

The ataractic effect is a central neuro-relaxing action – the result of a marked cerebral specificity – free of mental fogging and devoid of any major complications: no liver, blood or brain damage. This peace-of-mind component is also used in the lowest dosage range.

Supplied: Each green, scored, ATARAXOID oral tablet contains 5 mg. prednisolone (STERANE) and 10 mg. hydroxyzine hydrochloride (ATARAX). Bottles of 30 and 100.



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the first and only ataraxic-corticoid

araxoid*

prednisolone and hydroxyzine

Pfizer

combining the newest, safest tranquilizer, ATARAX® + the newest, most effective steroid, STERANE® (prednisolone)

simultaneously **controls the symptoms and the apprehension**

In Rheumatoid Arthritis, other collagen diseases, bronchial asthma and inflammatory dermatoses

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KARO® SYRUP . . . meets the accelerated nutritional requirement of early infancy

The high caloric requirements of infants, coupled with the fact that they have little ability to digest starchy food, are indications for the use of an easily digested carbohydrate milk modifier.

Karo places a minimum demand upon the digestive system during the first weeks of life. Even premature babies thrive on Karo because this easily digested, completely utilized, fluid mixture of dextrins, maltose and dextrose does not induce flatulence, colic, fermentation or allergy.

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Tetracycline-Antihistamine-Analgesic Compound

ACHROCIDIN is a comprehensive formula for treatment of complications of the common cold, particularly when bacterial sequelae are observed or expected from the patient's history or during widespread infections.

Distressing symptoms of malaise, headache, muscular pain, mucosal and nasal discharge are rapidly relieved.

And potent prophylaxis is offered against other diseases, such as otitis media, sinusitis, adenitis, and bronchitis, to which the patient may be highly vulnerable at this time.

ACHROCIDIN is convenient for you to prescribe—easy for the patient to take. Average adult dose: two tablets four times daily.

Available on prescription only

Each tablet contains:

ACHROMYCIN® Tetracycline	125 mg.
Phenacetin	120 mg.
Caffeine	30 mg.
Salicylamide	150 mg.
Chlorothen Citrate	25 mg.

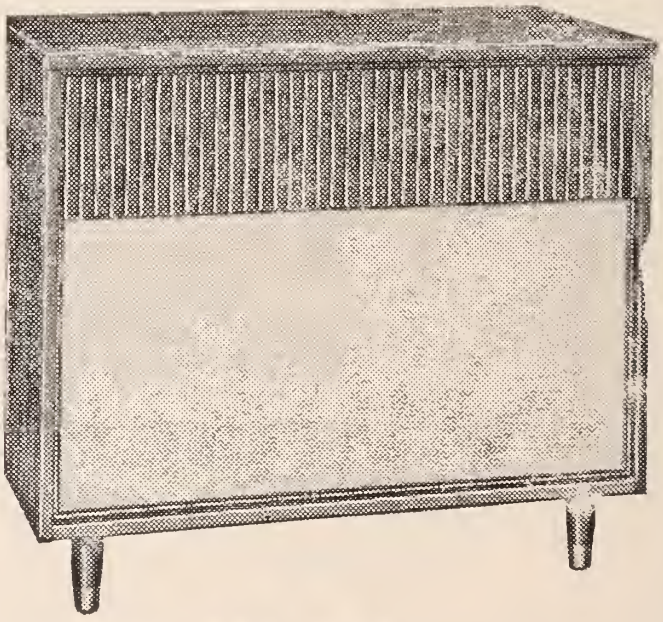
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Indications: **anxiety and tension states, muscle spasm.**

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Miltown®

Tranquilizer with muscle-relaxant action

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2-methyl-2-n-propyl-1,3-propanediol dicarbamate—U.S. Patent 2,724,720

SUPPLIED: *400 mg. scored tablets. Usual dose: 1 or 2 tablets t.i.d.*

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For prompt and effective relief, especially in many resistant allergic disorders, METR affords the benefits of two established agents with unexcelled anti-inflammatory, allergic and antipruritic effectiveness. ***supported by essential vitamin C***—for support and for postulated effect on prolonging steroid action ***no better corticost*** —original brand of prednisone...minimal electrolyte effects—METICORTEN ***no better*** ***histamine***—unexcelled in potency and freedom from side effects—CHLOR-TRIM effective against hay fever, pollen asthma, perennial rhinitis, acute and chronic urti angioneurotic edema, drug reactions, inflammatory and allergic eye disorders, pr and contact dermatoses.

formula: Each tablet of METRETON provides 2.5 mg. of METICORTEN (prednisone), 2 mg. of CHLOR-TRI maleate (chlorprophenpyridamine maleate), and 75 mg. ascorbic acid.

supplied: METRETON Tablets, bottles of 30 and 100.

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allergies

new

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ckly clears nasal passages • avoids rebound engorgement and
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position: Contains 2 mg. (0.2%) METICORTELONE acetate (prednisolone ace-
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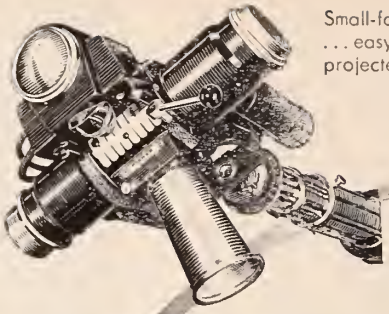
kaging: 15 cc. plastic "squeeze" bottle, box of 1.

ETON,* brand of corticoid-antihistamine compound; METICORTEN,* brand of prednisone;
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MT-J-576



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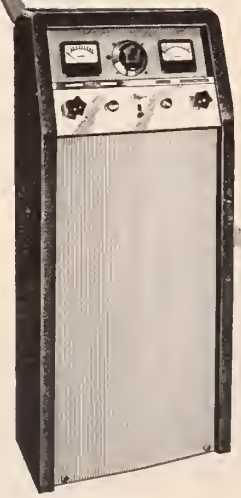


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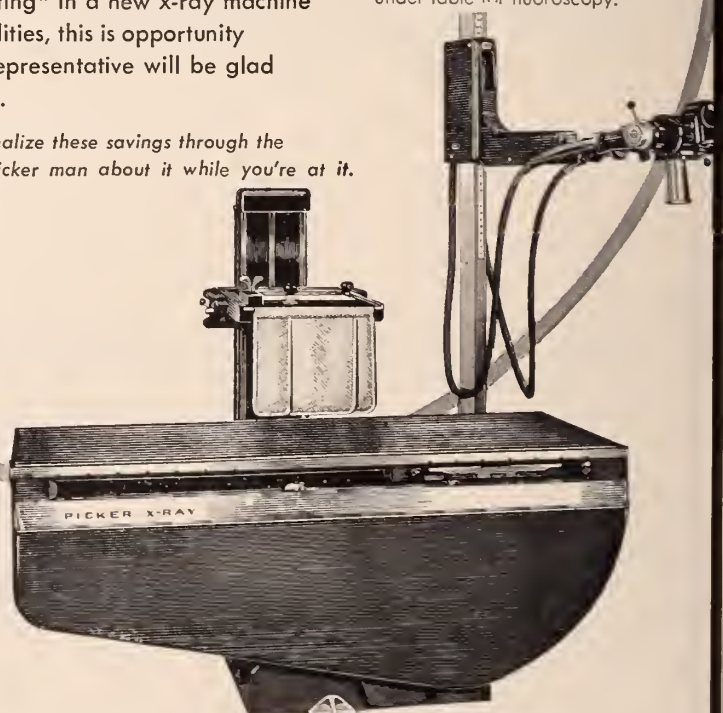
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Smooth-gliding floor-ceiling Twintrack tubestand rotates full circle with 90° clickstops. Rigid self-swallowing telescopic tubearm slips x-ray tube deftly into place under table for fluoroscopy.



Heavy duty Picker generator (200 ma, 100 KVP) and distinguished upright control cabinet. Automatic Manitor operation. Full-range time-KV selection without technical compromises.



High-style "prestige" table, luxurious finish. Clear access all around — front, back, both ends — no protruding floor obstructions. Poised hand-rock or quiet motor-drive. Weight counterbalanced fluoroscopic tower with either full size screen or Polyfilmer for 8" x 10" spotfilms (as shown here).

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..part of *every illness*

ANXIETY

s part of

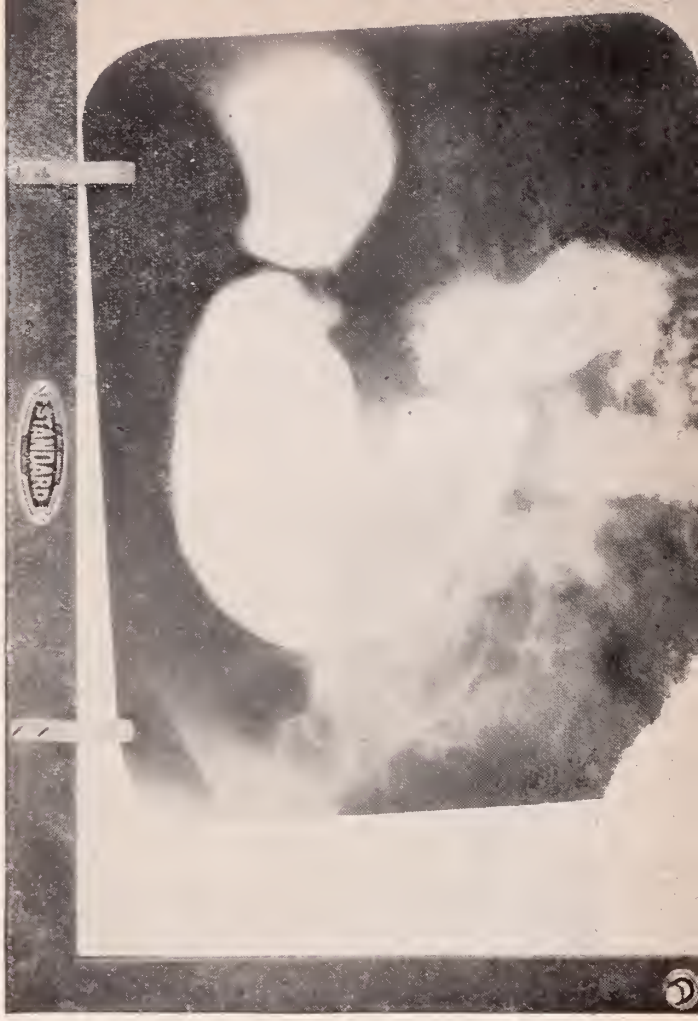
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MEPROBAMATE

(2-methyl-2-*n*-propyl-1,3-propanediol dicarbamate)

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. . . functional nervousness, including fatigue and anxiety, was by far the greatest detectable cause of recurrences of peptic ulcer symptoms, and in many instances it seemed likely that the same etiological factors were initially responsible for the ulcer."[1]

Peptic ulcer is a combination of the emotional and the physical. For total management, a combination of measures is often indicated. EQUANIL adds to the adequacy of routine treatment by countering psychic stress as a stimulant to vagal activity. It combats the anxiety and tension, and encourages restful sleep.[2]

In every patient . . . a valuable adjunct to the customary therapy

Supplied: Tablets, 400 mg., bottles of 50.

Usual Dose: 1 tablet, t.i.d.

1. Weiss, E., and English, O.S.: Psychosomatic Medicine. W. B. Saunders Co., Philadelphia, 1949, p. 358.

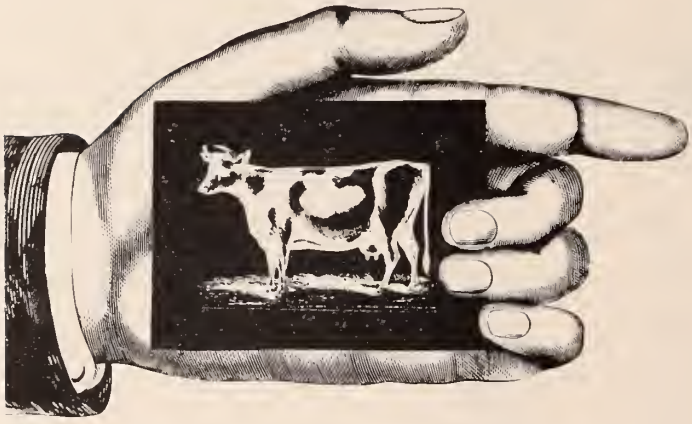
2. Lemere, F.: Northwest Med. *54*:1098 (Oct.) 1955.

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HI-PRO Spray Dried Modified Cow's Milk takes up where cow's milk leaves off. It gives a 3-to-1 protein-to-fat ratio to patients in need of biologically complete protein content and low fat intake.

HI-PRO provides a full quota of calories without danger of fat irritation in cases of fat intolerance or where digestive disturbances are present. Readily digestible, it is ideal in treatment of infant diarrhea, prematures, fat intolerance and normal newborns.

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Proteins are well-absorbed and supply calories lost by reduction in fat and carbohydrates.

prematures
Rapid growth plus low fat tolerance makes HI-PRO an ideal food.

fat intolerance
Protein is well-absorbed and caloric intake can be raised to any level without fat difficulties.

normal newborns
With HI-PRO, you can provide extra protein without fat for rapid growth and good tissue turgor.

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Protein	41%
Fat	14%
Carbohydrate	35%
Calcium	1.15%
Calories per oz.	121

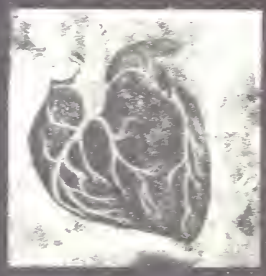


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'Enteric-Coated' Tablets

(Blair brand of reserpine-aminophylline)

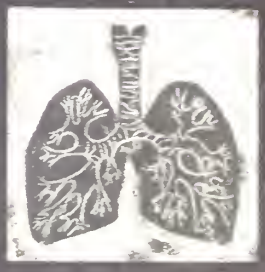
TO RESTORE EMOTIONAL TRANQUILITY AND REINFORCE CARDIO-PULMONARY FUNCTION IN ARTERIOSCLEROTIC AND HYPERTENSIVE HEART DISEASE, ANGINA PECTORIS, PAROXYSMAL (NOCTURNAL) DYSPNEA, AND PULMONARY EMPHYSEMA

Formula—each tablet combines:

Reserpine, crystalline	0.1 mg.
Aminophylline (in enteric-coated core)*	100.0 mg. (gr. 1½)

Supply—bottles of 100 tablets

...a preferred prescription whenever oral aminophylline is indicated...



SERPHEDRINE™

'Enteric-Cored' Tablets

(Blair brand of reserpine-aminophylline-ephedrine)

SYNERGISTICALLY ENHANCED SAFETY AND EFFECTIVENESS FOR PROMPT AND PROLONGED RELIEF OF ANXIETY AND BRONCHO-PULMONARY DYSFUNCTION IN BRONCHIAL ASTHMA, PULMONARY EMPHYSEMA, AND CHRONIC BRONCHOPULMONARY DISORDERS

Formula—each tablet combines:

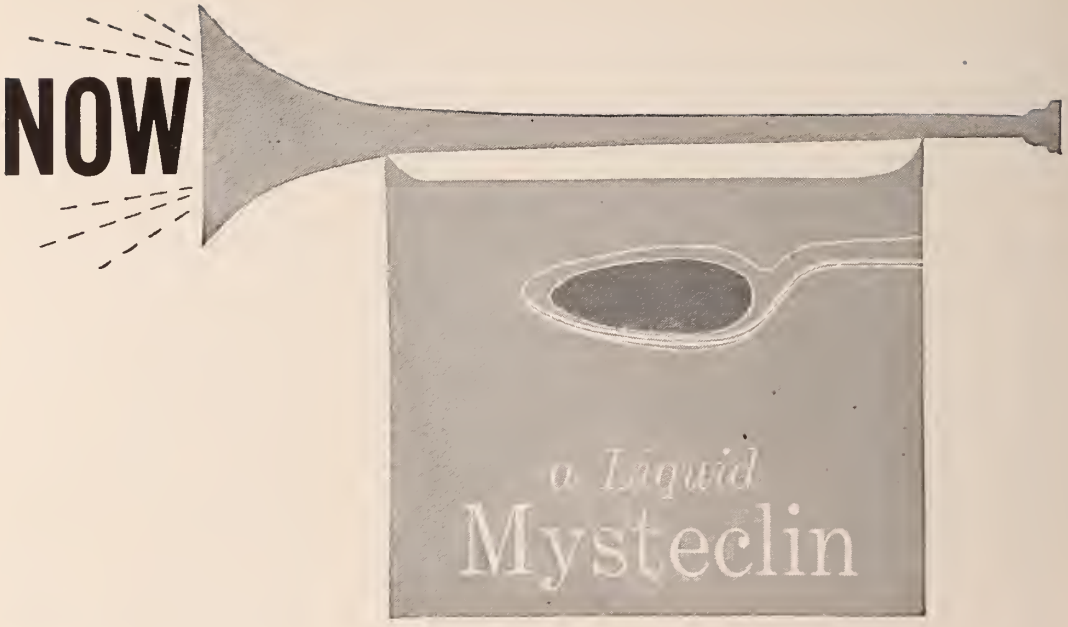
Reserpine, crystalline	0.1 mg.
Aminophylline (in enteric-coated core)*	100.0 mg. (gr. 1½)
Ephedrine sulfate	16.0 mg. (gr. ¼)

Supply—bottles of 100 tablets

...preferred whenever oral aminophylline-ephedrine is indicated...

**To help avoid gastric irritation and prolong protection.*

BLAIR LABORATORIES, INC./ SHORT HILLS, NEW JERSEY



MYSTECLIN SUSPENSION

Steclin-Mycostatin (Squibb Tetracycline-Nystatin)

Another form of the only broad spectrum antibiotic preparation with added protection against monilial superinfection

PLEASANT TASTING — Mysteclin Suspension is pleasantly fruit-flavored and will appeal to taste-conscious youngsters as well as to adults who prefer liquid medication.

BROADLY EFFECTIVE — Mysteclin Suspension provides well tolerated therapy for the many common infections which respond to tetracycline—and also acts to prevent monilial overgrowth.

READY-TO-TAKE — Mysteclin Suspension requires no reconstitution and can be given by simple teaspoon dosage to patients of all ages.

MYSTECLIN SUSPENSION: a fruit-flavored oil suspension containing the equivalent of 125 mg. Steclin (Squibb Tetracycline) Hydrochloride and 125.000 units Mycostatin (Squibb Nystatin) per 5 cc. teaspoonful. Supplied in two-ounce bottles.

Also available as Capsules (250 mg. Steclin Hydrochloride and 250,000 units Mycostatin) and Half Strength Capsules (125 mg. Steclin Hydrochloride and 125,000 units Mycostatin).

SQUIBB *Squibb Quality — the Priceless Ingredient*

'MYSTECLIN'®, 'STECLIN'®, AND 'MYCOSTATIN'® ARE SQUIBB TRADEMARKS

New Evidence on *Rauwiloid*®

confirms and defines superiority over other Rauwolfia preparations in the treatment of HYPERTENSION

- Rauwiloid represents the balanced, mutually potentiated actions[1] of several Rauwolfia alkaloids, of which reserpine and the equally antihypertensive rescinnamine have been isolated.
- Hence, reserpine is not the total active antihypertensive principle of the rauwolfia plant.
- Rauwiloid is freed of the undesirable alkaloids of the whole rauwolfia root. Recent investigations confirm the desirability of Rauwiloid (because of the balanced action of its contained alkaloids) over single alkaloidal preparations; "...mental depression...was...less frequent with alseroxylon..."[2]

The dose-response curve of Rauwiloid is flat, and its dosage is uncomplicated and easy to prescribe...merely two 2 mg. tablets at bedtime.

1. Cronheim, G., and Toekes, I. M.; Comparison of Sedative Properties of Single Alkaloids of Rauwolfia and Their Mixtures, Meet. Am. Soc. Pharmacol. & Exper. Therap., Iowa City, Iowa, Sept. 5, 1955.

2. Moyer, J. H.; Dennis, E., and Ford, R.: Drug Therapy (Rauwolfia) of Hypertension. II. A Comparative Study of Different Extracts of Rauwolfia When Each Is Used Alone (Orally) for Therapy of Ambulatory Patients with Hypertension, A.M.A. Arch. Int. Med. *96*:530 (Oct.) 1955.

Riker

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Rauwiloid is the original alseroxylon fraction of India-grown Rauwolfia serpentina, Benth., a Riker research development.

24-hour control

for the majority of diabetics



GLOBIN INSULIN

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a clear solution . . . easy to measure accurately

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ORAL PENICILLIN FOR *BETTER* AND *MORE CONSISTENT* ABSORPTION

"Because of the better and more consistent absorption of penicillin V from the intestinal tract, it would appear that this type of penicillin is preferable to penicillin G when oral administration is to be used."[1]

PEN·VEE·*Oral* and PEN·VEE *Suspension* permit new dependability in oral-penicillin therapy—dependable stability in gastric acid, dependable and optimal absorption in the duodenum. "Not being destroyed by acid in the stomach, as is penicillin G, penicillin V remains available in larger amounts for absorption."[1]

1. Martin, W. J., et al.: J.A.M.A. *160*:928 (March 17) 1956.

PEN·VEE* *Oral* and *Suspension*

PEN·VEE·*Oral* is Penicillin V, Crystalline (Phenoxymethyl Penicillin)
PEN·VEE *Suspension* is Benzathine Penicillin V Oral Suspension

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"You try to scrub the bathtub with your back aching morning till night!"

"I don't know about bathtubs, but two days ago I couldn't reach a shelf higher than that."

"I thought maybe I slept in a draft. Never had a stiff neck like this before."

"That's nothing. I went around with my arm in a sling for nearly two weeks— had to sleep with a pillow at my back so I wouldn't roll over on it."

"I thought I was getting too old for high heels— low heels didn't help. My leg hurt down to the ankle."

"That'
I'm o
feet
but it
my a
both



... safeguarded relief all the way across t

Prednisone + Acetylsalicylic Acid + Aluminum Hydroxide + Ascorbic A

Potent corticosteroid anti-inflammatory action complemented by r
analgesia; doubly protected with antacid and supplemental vitami

"My back was so tight I couldn't even get on and off the bus; now I can climb stairs."

"I hope he helps my knee that quick."

"Take it from me, you should be glad you saw him early in the game so he could do some good."

"Good?— why, he's got me doing exercises I haven't done in years."



read of common rheumatic complaints

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- brings specific, complementary benefits to the treatment of muscle, ligament, tendon, bursa and nerve inflammation
- for the initiation of treatment of milder rheumatic disease
- for continuous or intermittent maintenance in more severe rheumatic involvement

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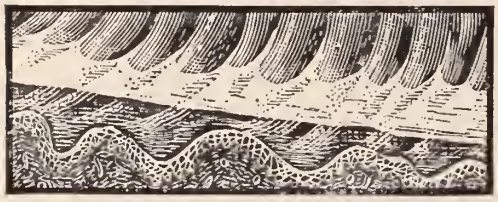
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jelly and liquid

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OF VAGINAL TRICHOMONIASIS

VAGISEC liquid is the unique trichomonacide that explodes trichomonads within 15 seconds. It is a proved combination of three chemical agents which penetrates to hidden trichomonads and eliminates failure of treatment and flare-ups due to lack of penetration.



VAGISEC liquid penetrates to trichomonads buried among the vaginal rugae and imbedded in mucus and desquamated cells.

Hidden trichomonads. Trichomonads do not exist in the vaginal secretion alone. They are vigorously motile and burrow deeply into the surface of the vaginal mucosa where cellular debris and mucus cover them. VAGISEC liquid lowers surface tension, penetrates the cellular debris and dissolves mucoid material[1,2] that lines the vaginal wall and lies buried among the rugae. It reaches and explodes hidden as well as surface trichomonads.

Unique overpowering action. VAGISEC liquid combines a chelating agent and two surface-acting agents that act in balanced blend to weaken the trichomonad's cell membrane, to remove its waxes and lipids, and to denature its proteins. The parasite imbibes water, swells up and explodes. *No other agent or combination of agents kills the trichomonad in this specific fashion, or with this speed.*

Trichomonads explode within 15 seconds. "Motion pictures taken through a phase-contrast microscope at 24 frames per second show that individual trichomonads are destroyed within 10 to 14 seconds after contact . . ." with solution of VAGISEC liquid.[3]

The Davis technique.† The remarkable speed and uniquely effective action of this trichomonacide are the result of the intensive research of its originators, Dr. Carl Henry Davis, well-known gynecologist and author, and C. G. Grand, research physiologist, who introduced the agent as "Carlendacide" and had it clinically tested by more than 150 physicians, including over 100 leaders in obstetrics and gynecology.[2,3] In this extensive evaluation, better than ". . . 90 per cent of apparent cures have been obtained. . . ."[2] For "the small percentage of women who have an involvement of cervical, vestibular or urethral glands, other treatments will be required."[3]

Office treatment. Expose vagina with speculum. Wipe walls dry with cotton sponges and wash thoroughly for about three minutes with a 1:100 dilution of VAGISEC liquid. Remove excess fluid with cotton sponges. Office treatments are an integral part of the Davis technique.

Home treatment. Prescribe both VAGISEC liquid and jelly. Patient douches with VAGISEC liquid every night or morning and then inserts VAGISEC jelly. Home treatment is continued through two menstrual cycles, but omitted on office treatment days. Douching contraindicated in pregnancy.

Summary. VAGISEC liquid penetrates to hidden trichomonads and explodes them in 15 seconds. VAGISEC jelly and liquid are nontoxic and non-irritating, leave no messy discharge or staining. VAGISEC liquid and jelly have been clinically tested and proved a remarkably fast-acting, effective treatment for vaginal trichomoniasis.

Active ingredients: Polyoxyethylene nonyl phenol, Sodium ethylene diamine tetra-acetate, Sodium dioctyl sulfosuccinate. In addition, VAGISEC jelly contains Boric acid, Alcohol 5% by weight.

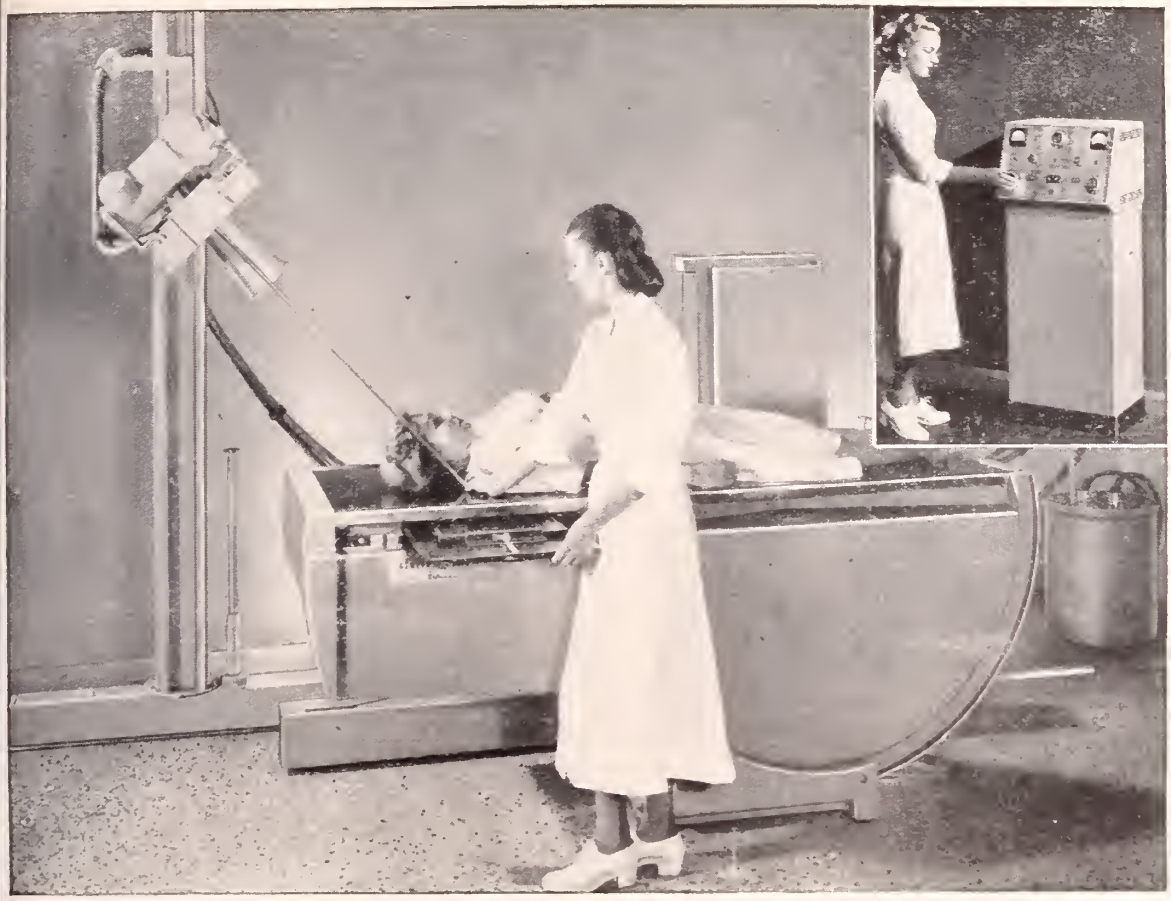
1. Davis, C. H.: Am. J. Obst. & Gynec. 68:539 (Aug.) 1954.
2. Davis, C. H.: West. J. Surg. 63:53 (Feb.) 1955.
3. Davis, C. H.: J.A.M.A. 157:126 (Jan. 8) 1955.

†Pat. App. for

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JULIUS SCHMID, INC., *gynecological division*

423 West 55th Street, New York 19, N. Y.



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Erythromycin in the treatment of osteomyelitis

8/3/55

CASE SUMMARY

On 6/2/55, patient, male, age 28, fell on an old fracture and refractured the middle third of the right femur, superimposed on an old osteomyelitis.

On 7/7/55, the wound was saucerized and a hemolytic S. aureus (coag. +) was isolated from the osteomyelitis. Disc sensitivities were: penicillin, 10 units; erythromycin, 10 mcg.; tetracycline, 10 mcg.

On 7/15, the patient was placed on erythromycin therapy 400 mgm. q. 6. h. Patient afebrile after erythromycin started. X-rays showed evidence of healing with callus formation. No septicemia and clinical evidence indicates control of the infection.

On 8/3, the cast was removed and leg recast. Wound was in good condition with minimal drainage.

Diagnosis: fracture middle third of right femur, complicated by osteomyelitis.

Result: erythromycin aided healing of the old osteomyelitis and kept the infection under control.

* *Communication to Abbott Laboratories*

ecific against

ccic infections

Specific—because you can actually pinpoint the therapy for coccic infections. That's because most bacterial respiratory infections are caused by staph-, strep-and pneumococci. And these are the very organisms most sensitive to ERYTHROCIN—even when in many cases they resist other antibiotics.

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Erythrocin®
(Erythromycin, Abbott)
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Erythrocin®
(Erythromycin, Abbott)
STEARATE

® Filmtab—film-sealed tablets; pat. applied for

Sedatives
- A.) hypothalamic — Reserpine
- B.) cortical — Mebaral

A.) Indications

1. Emotional instability
2. Anxiety
3. Tension states
   a.) Premenstrual
   b.) Menopausal
   c.) etc.

B.) Treatment - Tranquilize!

℞

Reserpine-c Mebaral

Tablets

usual dose: 1 tab. tid.



Winthrop

Each tablet contains
Reserpine - 0.15 mg.
Mebaral® - 30 mg.
(brand of mephobarbital)

KNOX Protein Previews





New Study Shows Gelatine
Restores Brittle Fingernails to Normal

Directions for making the Knox Gelatine drink in every package



Brittle, fragile or laminating fingernails are the bane of many a woman's existence. Yet this highly prevalent and distressing condition often has gone uncontrolled for lack of effective therapy. Now, you can promise these patients substantial relief in a large percentage of cases.

In a recent study[1] that confirmed previous work[2] Knox Gelatine was used to treat 36 women with fragile, brittle, laminating fingernails. The response was most gratifying. Except for three patients who discontinued the therapy, three diabetics, and two women who had congenital deformities, the splitting ceased and all other patients were able to manicure their nails to a full point by the time the study ended.

Optimal dosage proved to be one envelope (7 grams) of Knox Gelatine administered daily for three months. Efficacy has not been established with lesser dosage. If you would like more complete details of this work, just use the coupon.

1. Rosenberg, S. and Oster, K. A., "Gelatine in the Treatment of Brittle Nails," *Conn. State Med. J.* 19:171-179, March 1955.
2. Tyson, T. L., *J. Invest. Dermat.* 14:323, May 1950.

Chas. B. Knox Gelatine Company, Inc.
Professional Service Dept. SJ-19
Johnstown, N. Y.

Please send me a reprint of the article by Rosenberg and Oster with illustrated color brochure.

YOUR NAME AND ADDRESS

in inflammatory skin diseases



all the benefits of the "predni-steroids"
plus positive antacid action
to minimize gastric distress

ROUTINELY ACHIEVED WITH

'Co-Deltra'
(Buffered Prednisone)

Multiple Compressed Tablets



'Co-Hydeltra'
(Buffered Prednisolone)

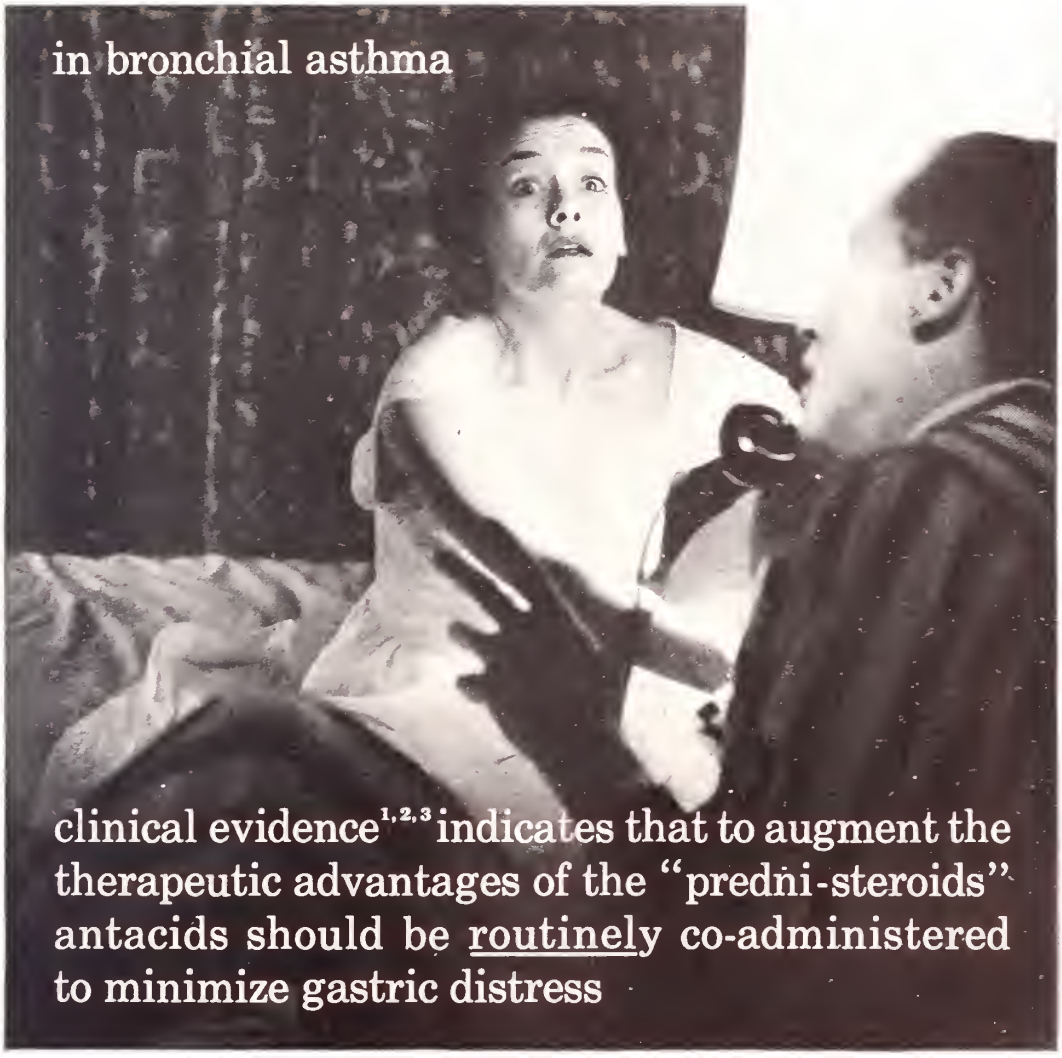
2.5 mg. or 5 mg. prednisone or prednisolone with 50 mg. magnesium trisilicate and 300 mg. aluminum hydroxide gel.

Clinical evidence[1,2,3] indicates that to augment the therapeutic advantages of prednisone and prednisolone, antacids should be *routinely* co-administered to minimize gastric distress.

References: 1. Boland, E. W., *J.A.M.A.* 160:613, (February 25,) 1956. 2. Margolis, H. M. *et al*, *J.A.M.A.* 158:454, (June 11,) 1955. 3. Bollet, A. J. *et al*, *J.A.M.A.* 158:459, (June 11,) 1955.

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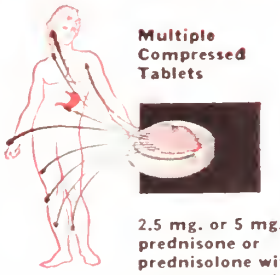
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clinical evidence[1,2,3] indicates that to augment the therapeutic advantages of the "predni-steroids" antacids should be routinely co-administered to minimize gastric distress

ROUTINE CO-ADMINISTRATION MEANS

'Co-Hydeltra'
(Buffered Prednisolone)



Multiple Compressed Tablets

'Co-Deltra'
(Buffered Prednisone)

2.5 mg. or 5 mg. prednisone or prednisolone with 50 mg. magnesium trisilicate and 300 mg. aluminum hydroxide gel.

All the benefits of the "predni-steroids" plus positive antacid action to minimize gastric distress.

References: 1. Boland, E. W., *J.A.M.A.* 160:613, (February 25,) 1956. 2. Margolis, H. M. *et al*, *J.A.M.A.* 158:454, (June 11,) 1955. 3. Bollet, A. J. *et al*, *J.A.M.A.* 158:459, (June 11,) 1955.

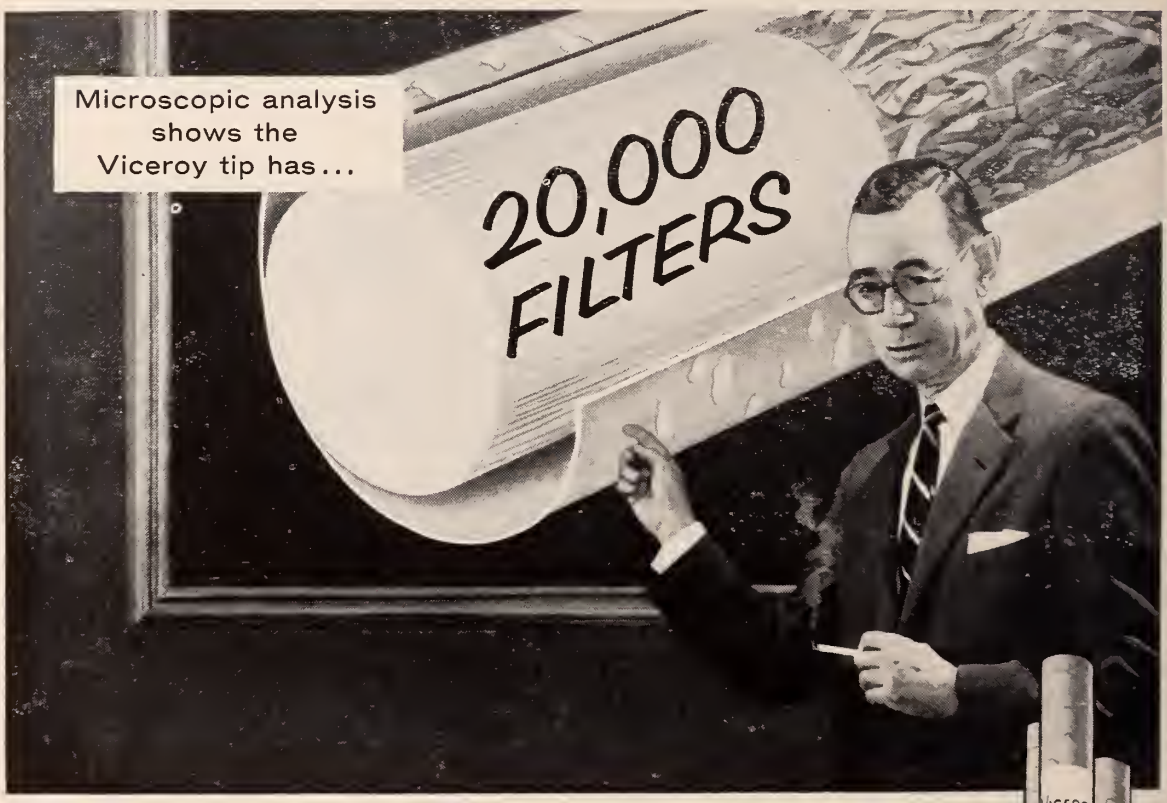
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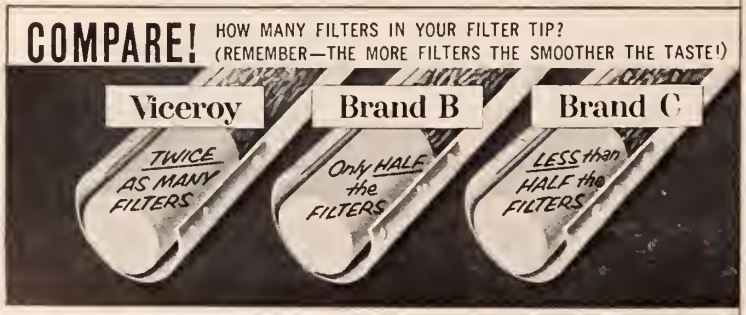


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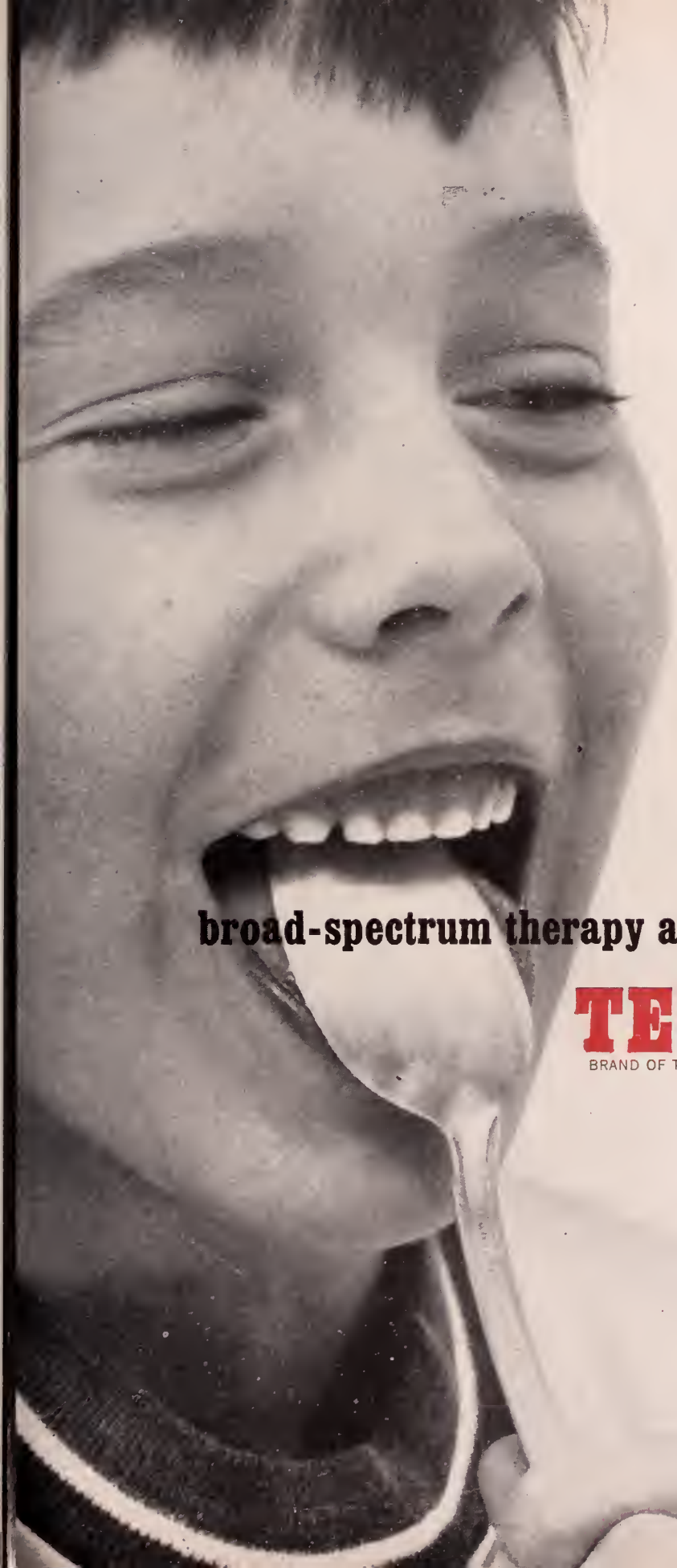
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125 mg. tetracycline per 5 cc. teaspoonful. Bottles of 2 fl. oz. and 1 pint, packaged ready to use (no reconstitution required).
READILY ACCEPTED delightfully different fruit flavor . . .
RAPIDLY ABSORBED fine particle dispersion—therapeutic blood levels within one hour . . .
QUICKLY EFFECTIVE well-tolerated tetracycline for prompt control of a wide range of infections.

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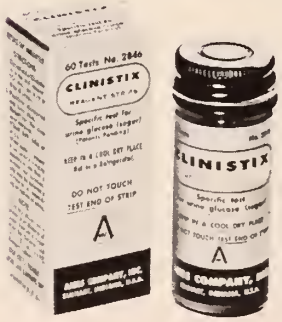
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daily check by mild diabetics, ▶
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Supplied: Bottles of 100 and 500 tablets

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Sterile Solution

Each cc. contains:
Methscopolamine bromide ..... 1 mg.

Dosage:
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Supplied: Vials of 1 cc.

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ACHROMYCIN*

Tetracycline *Lederle*

for prophylaxis and treatment of

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Posner and his colleagues[1] have reported on the use of tetracycline (ACHROMYCIN) in 96 cases of obstetric complications, including unsterile delivery, premature rupture of the membranes, endometritis, parametritis, and other conditions. They conclude that this antibiotic is ideally suited for these uses.

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ACHROMYCIN SF

ACHROMYCIN with STRESS FORMULA VITAMINS. Attacks the infection, bolsters the patient's natural defenses, thereby speeds recovery. Especially useful in severe or prolonged illness. Stress formula as suggested by the National Research Council.

SF Capsules, 250 mg.

SF Oral Suspension, 125 mg. per teaspoonful (5 cc.)

For more rapid and complete absorption. Offered only by Lederle!

dry-filled sealed capsules

[1]Posner, A. C., *et al.;* Further Observations on the Use of Tetracycline Hydrochloride in Prophylaxis and Treatment of Obstetric Infections, *Antibiotics Annual* 1954-55, pp. 594-598.

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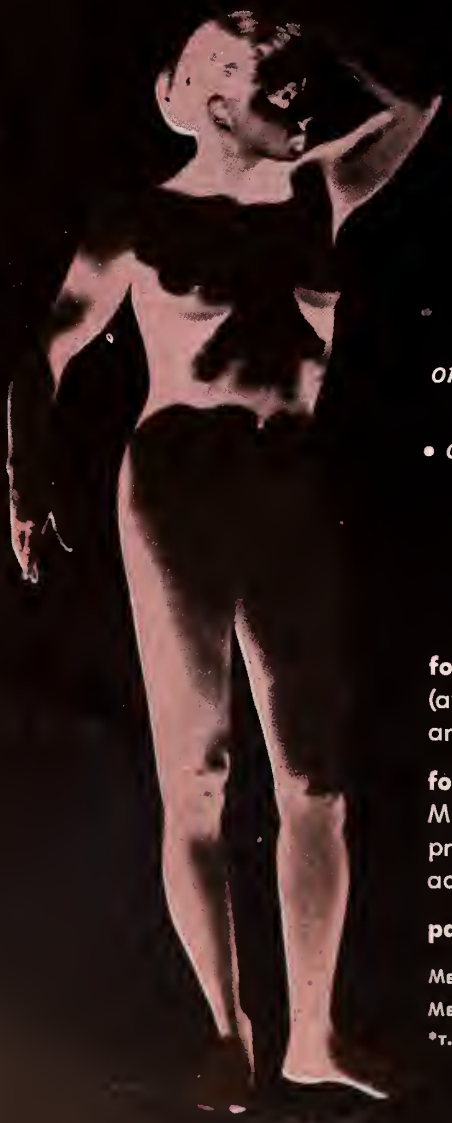
effectiveness in allergic

and inflammatory dermatoses

new

Meti-Derm cream 0.5%

with METICORTELONE, original brand of prednisolone



- *approximately*

twice the per milligram

anti-inflammatory activity

of topical hydrocortisone

- *cosmetically acceptable*
- *water-washable*

for effective local relief of allergic (atopic and contact) dermatoses, nonspecific anogenital pruritus.

formula: Each gram of water-washable METI-DERM Cream contains 5 mg. (0.5%) of prednisolone, free alcohol, in a cosmetically acceptable base.

packaging: METI-DERM Cream, 0.5%, 10 Gm. tube.

METI-DERM,* brand of prednisolone topical.

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*T.M.

...and adding dual control

to Meti-steroid skin therapy—

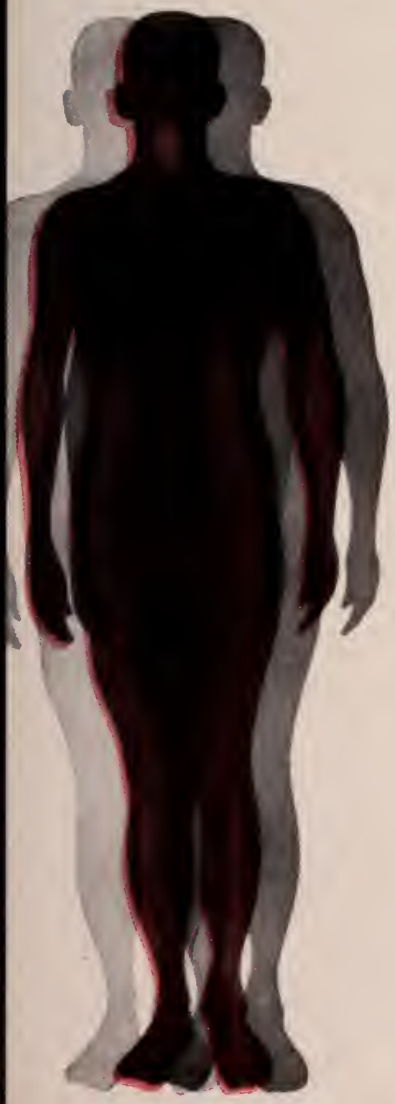
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against infection

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Meti-Derm ointment

with Neomycin



enhanced effectiveness

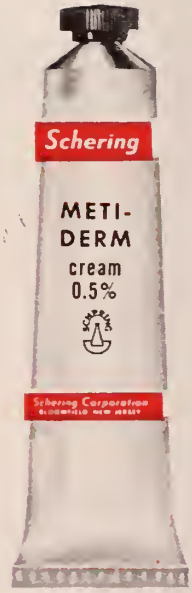
in allergic, inflammatory

dermatoses when

minor infection

is present

or anticipated



neomycin in addition to prednisolone, free alcohol—for protective coverage against virtually all pathogenic skin bacteria with a well-tolerated, *topical* antibiotic.

formula: Each gram of METI-DERM Ointment with Neomycin contains 5 mg. (0.5%) prednisolone, and 5 mg. (0.5%) neomycin sulfate equivalent to 3.5 mg. neomycin base.

packaging: METI-DERM Ointment with Neomycin, 10 Gm. tube.

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'Merthiolate'

(THIMEROSAL, LILLY)

'Merthiolate' is highly active under virtually all conditions; is relatively nonirritating and nontoxic

'Merthiolate' is germicidal in dilutions up to 1:4,000 in serum media and is relatively nonirritating in the concentrations suggested for use. It also maintains its activity in the presence of soaps. The fact that 'Merthiolate' is used as a bacteriostatic agent in fluids for parenteral administration gives strong evidence of its safety.

THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

The Semi-Centennial of the Food and Drug Law

The year now drawing to a close is the semi-centennial of the Food and Drug Act. It was in 1906 that President Roosevelt (Theodore, not Franklin) signed the bill into law. For the greater portion of America's history, manufacturers and sellers of medicines could, with impunity, mislabel, adulterate and misbrand their nostrums. A glance through advertisements appearing at the turn of the century shows a soothing syrup advertised as "curing wind, colic and diarrhea," an inhalant which cures tuberculosis by "cleansing and healing the pulmonary tubes" and an "eclecteric oil" which has "already cured diphtheria and cured deafness of twenty years." One manufacturer announced that his vegetable cure "cured cancer without the aid of a knife." In one paper, a display advertisement from an Indianapolis sanatorium announced "Cancer Cured with Soothing Balmy Oils." A Chicago company reported that its "Red Clover Blossoms, together with fluid extracts cure cancer, catarrah and all blood diseases." A clergyman is cited as testifying that a preparation of *piper methysticum* from the banks of Ganges is a "positive specific cure" for gravel and dropsy. The manufacturer advertised that this shrub "had the extraordinary record of 1200 hospital cures in 30 days."*

The first effort to require honest labelling and clean food and drugs, was an 1879 bill that died aborning. Every year thereafter, friends of drug and food reform had bills introduced into the Senate or House, but until 1906, they all died. When, beaten by the big stick of Teddy Roosevelt, Congressmen began to get serious about pure foods and drugs, the opponents went into a huddle. On the face of it, you wouldn't think it possible that any one could oppose honest labelling. But they

*Some of the historical material in the first paragraph is adapted and paraphrased from an article in *What's New*. Thanks are expressed to Abbott Laboratories for permission to do this.—Editor.

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did. One newspaper jeered at Harvey Wiley as chief janitor of the people's guts. (Dr. Wiley was not an M.D. He was chief chemist to the Department of Agriculture). Other papers said that any more Government regulation meant one more step to socialism. (The word "communism" hadn't been invented yet.) Then there were states righters who said that food and drug regulation was not, in our Constitution, an authorized Congressional activity: it belonged therefore to the states. This would have resulted in a situation where food could be mislabelled in one state and sold in another and neither would have jurisdiction. It was predicted that if the law made misbranding a crime, a manufacturer who said he had 5000 grains of oatmeal in the carton would have to sit down and count each grain one at a time. This would destroy the commercial food purveying business. Of course those who had financial stakes in the canning, packing or grocery businesses did not like the idea of a federal policeman breathing down their necks. But you could not forever insist on the right to print fraudulent labels. When the White House finally turned on the pressure—just 50 years ago—the opposition collapsed and the bill passed handsomely.

For this consummation credit goes to many people. To Harvey Wiley who did the experimental work and provided the technical background; to President Roosevelt who gave it the needed political push; to Edward Bok who refused to carry patent medicine advertisements in the *Ladies' Home Journal* and who made that journal a powerful organ on behalf of honest drug labelling; to Samuel Hopkins Adams, who put his potent pen to work exposing quackery; to a few American magazines—notably *McClure's*, *World's Work*, *Collier's*, the *Independent* and *Cosmopolitan* which risked the wrath of some advertisers by campaigning for pure milk, food and drugs and—let it be said—to organized medicine, the county and state medical societies, and the American Medical Association which threw its then slender resources into the fight for pure food and pure drugs.

We could scarcely practice today without the support and protection offered by this law. Without it, an unscrupulous distributor could safely take the label of a potent drug and paste it on a bottle of cream soda or a box of lactose tablets. No federal law could stop him. Without it, we would never know how strong a tincture or fluid extract was. Without it, a greedy manufacturer could throw into the market a completely untested drug and let the unsuspecting public serve as its guinea pigs, with innocent doctors as the experimenters.

There is endless argument about the role of Government in the regulation of daily life. Between the proponents of a welfare state and the advocates of *laissez faire* there is always controversy. But no one now denies that it is a proper function of Government to protect people against swindlers and thieves. And the fraudulent medicine advertisement is a particularly malicious combination of thievery and swindling.

Before we dislocate our shoulders with congratulatory back slapping, however, let us assess our own prescription habits. If we prescribe a drug today, the patient will get what we call for. It will be clean, unadulterated and honestly labelled. The danger now is not that a manufacturer will issue impure drugs or that a pharmacist will dispense contaminated ones. The danger now is that, under the incessant barrage of pharmaceutical advertising we doctors will be tempted to take the easy way out—to reach for a pen and scrawl an Rx for the sedative, stimulant, vitamin, or steroid touted by the latest detail man or screamingly proclaimed on the glossiest brochure in today's mail. Examination of the prescription files of a large retail pharmacy will show, over the years, fluctuating fads and fashions. The cycle seems to vary with promotional intensity rather than with demonstrated therapeutic effectiveness. Some busy prescribers seem to hand out medication with the automatic reflex response of a slot machine yielding chewing gum. Indeed, a recent *New Yorker* shows a subway slot machine ready to dispense meprobamate along with chocolate bars and detective stories.

It would be a grim jest, if, after a half century of the Pure Food and Drug Law, our patients were getting toxic or ineffective medications because some of us found slot machine prescribing easier than the weighing of indications and contra-indications.

Extrasensory Perception?

On page 528 of this issue, we publish a review of the Ciba sponsored symposium on extrasensory perception. We doctors believe that you can't sense anything except through sensory channels. So the term "extrasensory perception" means nothing; or it means "nonsensory sensation" which is nonsense. What the parapsychologists really mean is not "extrasensory" but *unusual* perception — that is the "sensing" of something which is delivered to the brain outside the presently recognized ten senses of sight, hearing, smell, touch, pain, temperature, vibration, position, taste and muscle-joint sensations.

Some of these sensory channels have been demonstrated in comparatively recent times. It would be arrogant to insist that we now know all the answers and that henceforth no amount of biologic or neurologic research will ever disclose any other sensory pathways outside these ten. Instrumentation (television and fluoroscopy for instance) has already vastly extended the range of existing senses (sight and hearing in these two examples). It would be fatuous to say that we will never have any better instruments for extending our sensory range. One would have to be insufferably smug to insist that Nature ends with our sensory ceiling, and that anything beyond that is "supernatural."

There is another half to this problem. If telepathy is to be proved, it will not be enough to develop a receiving mechanism in the percipient's brain. It will also be necessary to show that—and how—mental activity can escape from the skull within which it originates.

Actually we already know that mental activity can radiate beyond its confining skull. The electro-encephalogram alone shows that. The brain radiates tiny electrical currents which, faint as they are, penetrate two layers of skull and are strong enough to be picked up by electrodes. Furthermore, these waves vary with the subject's state of consciousness, attention and mental activity.

In theory, then, the potential for radiating mental activity through and beyond the skull is already there. What is missing is a workable receiving and interpreting device.

Still, birds and bees do it. Somehow, a bird migrates to the same spot every winter, guiding himself without maps, radar, compass or clock, receiving some kind of sensory instruction which keeps him flying as the crow flies to an invisible destination. Bees locate water, maybe by recognizing the impact of humidity on their antennae and then going in a bee line to the water source. The usual sensory channels simply cannot explain these operations. Some kind of *unusual* perception is obviously involved. Calling it "instinct" explains nothing.

But the parapsychologists have still not proved the case for human telepathy, though the potential is certainly there. The statistical technic, favored by parapsychologists, is not convincing to the intelligent but mathematically naive man. Most of these studies depend on "guessing" designs on cards to see if the subject is clairvoyant or has telepathic powers. In the standard experiment, there are 25 cards in a deck, with five different designs. The subject tries to "guess" the design of each card either by "reading the mind" of a witness who is looking at the cards or by clairvoyance. Chance alone will give you 5 right answers. It is hard to believe that, if you get 7, you must be clairvoyant. The mathematician insists that getting these 2/25 above "random selection" could be due to chance only once in a million times. Maybe. But to the intelligent man in the street, getting 18 wrong answers out of 25 is nothing to write home about.

We can believe telepathy as soon as the parapsychologists give us one repeatable experiment, which any competent investigator can do with similar results. More impressive than all the statistics will be one consistently predictable result or one indefinitely repeatable experiment. Until that day, the sensible verdict must be, "not impossible, but not proved."

What Does "Blue Shield" Mean to You?

Have you ever stopped to ask yourself why 37 million Americans have enrolled in Blue Shield?

Blue Shield and its companion Blue Cross have accomplished the most spectacular enrollment of any insurance program ever offered the American people—and by relatively "low pressure" sales methods. This accomplishment has been possible because there is now an almost universal desire for protection against the costs of unpredictable illness. The chief reason so many people have chosen Blue Shield is that it is supported by the medical profession. Most people do have confidence in the nation's doctors.

More Americans have chosen Blue Cross than any other hospital insurance program because Blue Cross is sponsored by the hospitals. The public believes in the integrity and efficiency of our voluntary hospital system.

Doctors and hospitals have created for themselves a store-house of good will in these Plans. But the preservation of this great asset depends upon eternal vigilance on the part of physicians and hospitals.

When the doctor speaks well of Blue Shield, when he renders the best service he can, he tries to conserve the resources of Blue Shield against extravagance or abuse. When he conscientiously fulfills his voluntarily accepted obligations as a Participating Physician, then he is helping to preserve and increase this asset. He is helping to make ever more formidable the shield that protects the freedom of medical practice.

Blue Shield is also a bridge of common interest and mutual benefit between the doctor and his patient—it is evident to each of the trust and confidence of the other. Blue Shield is an assurance to the patient of prepaid service when he needs it—and to the doctor, it assures prompt payment for his services.

Color Coding of Drugs

One of the suggestions made by efficiency engineers (part of the new profession of standards control) is the wider use of color coding. It is good to know that the red, green and white wires in your electric toaster, or the blue-wrapped or yellow-wrapped pipes under the street have special meanings. Advertisers urge you to buy the package in the blue wrapper or to look for the green-and-white box. We in this JOURNAL have resisted all efforts to abandon our slightly bilious cover color because, after half a century, it has become the familiar, old reliable, yellow cover, a sort of trade-mark.

Now comes the suggestion that medications be color-coded, so that a nurse would be unlikely to inject atropine when the order called for aconitine or to dispense Gelusil® for Gantrisin®. One might, indeed, visualize a complete coding system, whereby stimulants were red, and sedatives blue, antacids mauve, and hematinics purple. Diuretics, of course, would be yellow, estrogen preparations gold, and laxatives brown. Then a new meaning would be given to the shabby old phrase "broad spectrum," for indeed it would be a literal spectrum.

But the time would come when interns, nurses, pharmacists, orderlies and relatives would rely on color. Inability to distinguish violet from purple would mean confusion between stimulants and tranquilizers. Color-blindness would be as serious to a nurse then as alexia is today. Since there are more kinds of drugs than there are substantially different colors, more than one kind of drug would have to be stained in the same color—even though there might be a difference in hue.

It is said that colored piano key-boards make it easier for a 7-year old to learn to play a piano. Could be. But the dispensing of medication had better remain a monopoly of literate adults.

HENRY C. CROSSFIELD, M.D.

West Orange

Office Management of the Hypertensive Patient*

In this well-reasoned monograph, Dr. Crossfield compares the efficacy of the various tension-reducing drugs, weighs the role of changed living conditions and provides a quick survey of the physiologic and hormonal anlage of hypertension.

THE trend in the treatment of hypertension may be quickly stated to be toward the search for a magic drug that will block the emotional and sympathetic tensing impulses that elevate the blood pressure. Despite rauwolfia serpentina, hydralazine and methonium derivatives, we do not have the proper drugs. Even if we did it is not certain that the problem would be completely solved.

The complexity of the nervous system that controls the blood pressure reminds us that it can be stimulated in many ways to increase the vascular tone. The cause of *secondary* hypertension is usually only one condition such as brain tumor, hyperthyroidism, eclampsia, impaired circulation to the kidneys or even arteriosclerosis. But the cause of *essential* hypertension is still thought to be due to more than one condition. Often one reads that it is due to a sympathetic hypertonia plus hormonal and humeral influences that makes it persistent.

PHYSIOLOGIC FACTORS

THE nervous mechanism's chief center is the vasoconstrictor center in the medulla. This is connected with the sympathetic ganglia and to the nerve endings in the smooth muscle of the arteriolar wall, the tone of which has so much influence on the degree of blood pressure.

The ways of stimulating this vasoconstrictor center are: (1) emotional impulses from the cerebral cortex; (2) thermal changes through the hypothalamus; (3) carotid sinus tests of the blood for carbon dioxide, oxygen and other elements such as toxins and drugs are transmitted to the vasoconstrictor center; (4) the aortic nerve plexus sends impulses according to the state of distention of the aorta; (5) the sympathetic and parasympathetic systems bring impulses from the internal organs; (6) the sensory nerves send impulses by reflex arcs relative to pain and anxiety which stimulate the medullary portion of the adrenal gland to increase the secretion of the catacholamines, norepinephrine or arterenol and epinephrine. The brain, heart and kidneys have their own control of blood flow and pressure to some extent which fortunately helps to protect them in case of shock or extreme pressure.[1]

The most dramatic demonstration of the effect of the nervous control of blood pressure is seen in spinal anesthesia which drops the

*Read May 15, 1956 before the Section on Cardiovascular Diseases, at the Annual Meeting of The Medical Society of New Jersey.

pressure moderately. If the anesthesia is allowed to get too high, it causes shock. In the more severe cases of hypertension its effect is lessened which suggests other than nerve factors must be present. Most commonly these unknown factors are thought of as hormones and humeral substances. Many of these substances found in small amounts in the blood will increase blood pressure. None have been found consistently to explain persistent hypertension.

THE adrenal hormones from the medullary portion norepinephrine and epinephrine have well-known pressor effects. The cortex produces many hormones. Desoxycorticosterone will produce hypertension after repeated injections. Aldersterone, the salt-retaining hormone, would be expected to have a pressure effect. Cortical hormones are necessary for renal pressure agents to cause hypertension. Only an occasional case of Addison's disease is able to maintain hypertensive pressure levels on salt alone.

The pituitary gland has at least one hormone that exerts pressor effects. The somatotrophic hormone will produce hypertension, but only if the adrenal cortex is present. In Cushing's Disease the tumor causes hypertension, and in Simmond's Disease there is hypotension due to pituitary deficiency.

The enzyme renin that forms in the kidney tubules when acted upon by a globulin from the liver (hypertensinogen) is converted to angiotonin. This is a strong pressor substance. Any reduction in blood flow to the kidneys increases the formation of renin and a rise in pressure follows as Goldblatt [8] showed. Vasoexcitor and vasodepressor material, described by Shorr, Zweifach and Furchgott [9] in the blood of dogs when they were thrown into shock, does not seem to effect pressure except momentarily.

An extract of blood from hypertensive patients called "pherentasin" has a weak pressor effect but is found in such small quantities that its significance is doubtful, or at least unknown.

Thus we may say the adrenal and pituitary glands, the kidneys, and the liver all produce substances that affect the blood pressure, but the cause of sustained essential hypertension is not known. We *do* know that it does start to develop in some shortly after puberty or in the twenties or early thirties. In others it begins later in life, especially after fifty. This may suggest a slight difference in etiology; yet those who develop excessive pressure later may be a milder or delayed form of the former. The influence of heredity including body build, hormone balance and habits of eating on this younger group may be an important factor, but statistical analysis seems impossible. Most young persons who show evidence of being hyper-reactors will develop hypertension after 10 to 15 years but in 25 years of practice one will see a few who do not. The cold pressor test has been found helpful especially up to middle age in predicting the future tendency.

LIVING HABITS

EVALUATION of living habits is usually difficult. The patient who moves rapidly and is always alert seems less likely — surprisingly enough—to have hypertension than the one slow of motion, very careful, deliberate, and resentful of being rushed. Perhaps the latter individual has an emotional conflict that keeps him on guard and distrustful. Selye [10] has publicized the stress syndrome and everyone has observed the vasoconstriction in hands and feet during emotional strain, yet there is no proof in the literature that emotional stress alone causes essential hypertension. However, the patient should be encouraged to talk out his complaints both medical and otherwise.

Adequate rest is essential for normal relaxation, which has a hypotensing effect. Many of these patients should go to bed at nine o'clock. The diet is important, as demonstrated by the occasional case that will follow a low salt, low protein regimen, such as a modified rice diet. Whether the benefit is due to its low salt content or to its alkalinity or its effect on the metalloenzyme balance or the metallocorticoid pro-

duction is not known. Schroeder [2] has called attention to the fact that all hypotensive drugs used have only one thing in common: their ability to bind trace metals. These metals are obviously ingested in the food. Tipton, *et al.*[11] demonstrated the presence of cadmium in the kidneys of adults though none was found in infants. Since there is less risk involved in changing one's diet than in taking strong drugs, it is only reasonable to utilize that method of treatment if it can be made effective. The use of coffee, tea, and alcohol—in moderation—has not been found harmful. The reduction of excessive weight is advocated by everyone and it is especially helpful in those who have gained it rapidly and recently. This occurs frequently in women after the menopause. Adrenal cortical adenomata should be suspected according to Schroeder [2] in those with a central type of obesity and some change in their sex characteristics.

DRUG TREATMENT

THE drug treatment for hypertension throughout the country does not seem to be too different. Many doctors advise against preparations of two or more drugs in one tablet or capsule, since the dose of each should be varied separately, though they are given at the same time. The four types of drugs commonly used are (1) rauwolfia serpentina preparations usually reserpine; (2) protoveratrine A and B; (3) hydralazine; (4) ganglion blocking agents, usually reserved for the severe types.

Burgess [3] reported on an 18 to 34 year follow-up of 100 cases of essential hypertension. Of these patients, 68 were over 50 years at first examination, and these lived 1.2 years longer than their life expectancy. Thirty-two were under 50 years of age when first seen and they failed by 7.6 years to live up to their life expectancy. If one accepts these figures, or if they are verified, treatment with the new strong drugs of those past 50 years of age should be given only in selected cases, since their prognosis is good. But the treatment of those under 50 years should be improved with the present day medicine, provided the doctor can get intelligent cooperation and can give continuous treatment. In actual practice, it is difficult to draw a sharp line at the age of 50. If there has been a cerebral accident or congestive heart failure, adequate treatment with drugs is thought to prolong life. Malignant or rapidly progressive hypertension should be treated only if the treatment can be continued and the azotemia is not severe.

THE mild or early case of hypertension usually may be controlled by reserpine alone, provided no mental depression or agitation develops. Adjustment of weight, diet, and rest is routine in *all* cases. It is assumed that all patients in the younger age group wish to treat their hypertension. The dose of reserpine is usually from 0.1 to 1 milligram per day, but the smaller doses are less likely to cause nasal swelling, diarrhea, insomnia and nightmares. At this level, psychotic depression should not be expected.

If this treatment is not adequate at the end of one to two months, then one considers adding protoveratrine. This must be done very gradually to prevent vomiting. Meilman [4] advises dividing it in four dose, ½ hour after meals and at bedtime. The pattern he suggests is: 0.5 milligrams, then 0.25, then 0.5 again and then 0.25 milligrams. The dose should be increased very slowly if at all. The unpleasant effects of protoveratrine are due to parasympathetic over-activity. If large doses are used, heart block and extra systoles may develop. This would require atropine to relieve the symptom. Unpleasant side effects such as the nausea and depression may persuade the patient that the strict diet is less objectionable than large doses of even these relatively mild drugs. The majority of essential hypertensive patients probably fall into this group of Smithwick's grade I and II. They should have a full and adequate trial on diet, rest, adjustment of psychiatric problems and these two mild drugs, reserpine and protoveratrine. If this treatment fails or is interrupted, there is no rebound that would make further treatment more difficult. This is reported to be a safe, if sometimes in-

effective, treatment for office practice. No deaths have been reported due to the drugs.

About 30 per cent of this group will need something more to control their pressure; or perhaps the protoveratrine causes so much nausea that the patient wishes to change the treatment. In this case reserpine and hydralazine are given. Lee and his co-workers[5] set 300 milligrams as the maximum dose for hydralazine. They used less when possible. Therapeutic effectiveness was said to be attained without significant toxicity and in no case was it necessary to discontinue treatment. They concluded toxicity is partly due to dosage.

SMALL doses are appropriate for the weaker drugs only. When methonium compounds are used, it is important, as Schroeder[2] states, to use enough to bring pressure back to normal and keep it there or a tolerance will develop. Otherwise, toxic manifestations may develop from the larger doses necessary to produce normotension later. There are in everyone's practice a few cases of the more severe type, either of malignant or rapidly progressing hypertension or advanced essential hypertension with considerable arteriosclerosis. These pose the big problem of using ganglion blocking agents. Then the physician, according to Schroeder,[2] should "weigh the risks of the disease against the hazards of therapy." If the physician and patient decide to proceed with methonium treatment, it should be understood that it cannot be started in the office because the dose should be stabilized in the hospital. If the treatment is started, it must never be stopped, at least in the foreseeable future otherwise the greater problem of tolerance to the drug would be present. After all this is understood, reserpine, hydralazine, and a methonium compound regimen may be initiated. It has seemed worthwhile in selected cases such as those with malignant hypertension or those that have had a cerebral hemorrhage or congestive heart disease.

During the past year or more, experimental work[6] has been done on another ganglionic blocking agent called Su-3088. This is not a methonium but has a similar ganglionic blocking effect on the patient. Winsor[7] considers blurred vision which seems to occur earlier with this drug than with the methoniums a helpful sign in determining the onset of undesirable side effects. It is said to have two principal advantages over methonium compounds. First its effect lasts longer and therefore the patient need not take so many tablets. Secondly, it is better absorbed with less variation in the hypotensive effect.

It seems probable from the experience of others that like all drugs that lower the pressure radically Su-3088 should not be initiated unless it is going to be continued, though how much tolerance a patient develops has not been determined yet.

There are some severe hypertension patients who desire treatment, yet do not wish to continue the drugs or perhaps have not gotten satisfactory results, who may be referred for sympathectomy.

The tendency seems to be a swing back toward more emphasis on diet. There is a lot the medical profession does not know about diet and new ideas are being developed rapidly. There are many patients who wish to take a pill or nothing, but a few wish to be more conservative about their problems.

Another trend in the treatment of hypertension is to consider the specific etiology or etiologies more carefully and attempt to find drugs more effective for that particular type, just as we now favor hydralazine in the milder kidney type, protoveratrine for eclampsia and reserpine for the mild case that needs a tranquilizing effect.

Llewellyn Park

Bibliography will appear in author's reprints.

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Hyponatremic Shock in Urologic Disease*

Sodium depletion causes shock. Until the tonicity of the extracellular fluid can be restored, this shock persists. Anything which causes excessive excretion of urinary salts may lead to this kind of shock. The physiologic and clinical implications of this are reviewed by Dr. Fernicola.

The development of shock due to sodium depletion is insidious. The diagnosis is not readily made when predisposing factors and precipitating causes of this serious electrolyte derangement are not recognized. Sodium loss occurs by way of the skin, gastro-intestinal tract, kidney and in profuse exudates and transudates. Low serum sodium concentration may be due to dilution rather than depletion. Dilutional hyponatremia not infrequently supervenes in cases of heart and liver disease and carcinoma. Dilutional hyponatremic shock has recently been offered as a concept of the transurethral prostatic resection reaction.[1]

Urinary salt loss due to altered kidney function may cause profound depletional hyponatremia, which is encountered in such conditions as adrenal insufficiency, chronic nephritis, and diuresis. The alleviation of a variety of obstructive uropathies may be followed by excessive urinary salt loss.[2] Critical depletion of salt and water has been observed following relief of chronic lower urinary tract obstruction.[3]

Peripheral circulatory collapse may be a predominant manifestation of the acute salt depletion syndrome. The mechanism of this grave state of circulatory inefficiency is not completely understood. The hemodynamic changes are intimately related to the plasma volume and tonicity of extracellular fluid.[4]

Purpose of this paper is to call attention to the relationship between the recovery phase of urinary tract obstruction and the development of sodium depletion shock and to present the clinical features and therapeutic principles of hyponatremic shock. An unusual illustrative case is presented.

A 37-year old woman was admitted to St. Michael's Hospital in a moribund condition. A hysterectomy had been done at another hospital eight days previously. No urine was voided since the time of operation.

Examination revealed an acutely ill, listless and stuporous woman. Her abdomen was considerably distended, and a fluid wave was elicited. About one ounce of very cloudy urine was obtained on catheterization. The blood non-protein nitrogen was 240 milligrams per cent. The blood urea nitrogen was 75 milligrams per cent. Diagnosis was: intraperitoneal urinary extravasation due to bilateral ureteral injury incident to hysterectomy.

Without anesthesia the weakened portion of the recent midline suprapubic incision was perforated with a Kelly clamp, and a considerable amount of fluid gushed out of the abdomen. A silver drain was inserted into the wound to insure drainage.

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*From St. Michael's Hospital, Newark. This paper was read May 16, 1956 at the Urology Section of the Annual Meeting of The Medical Society of New Jersey.

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2. Wilson, B., Reisman, D. D. and Moyer, C. A.: Journal of Urology 66:805 (Dec.) 1951.

3. Peirson, E. L.: New England Journal of Medicine 253:360 (Sept. 1) 1955.

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After six days of supportive treatment her condition improved. Profuse drainage of urine continued from the abdominal sinus. The blood urea nitrogen decreased at 27 milligrams per cent.

Ten days later, an intravenous infusion of 2000 cubic centimeters of 5 per cent glucose in distilled water was given. The patient then complained of nausea, dizziness, weakness and numbness and cramps in her hands. She became cold and clammy. Blood pressure was imperceptible. Leucocyte count at this time was 28,000 and blood urea nitrogen was 60 milligrams per cent. Blood protein was 6 grams per cent; serum chloride, 86 milliequivalents per liter; carbon dioxide combining power, 21 milliequivalents per liter; serum sodium, 111 milliequivalents per liter, serum potassium, 6 milliequivalents per liter. The Thorn test was negative. The measures instituted to treat the patient's shock were continued for five days and included three liters of 5 per cent glucose in isotonic saline with continuous levarterenol† in each 24 hours, ten cubic centimeters of adrenal cortical extract every 8 hours and Trendelenberg position. One liter of plasma was given initially. Systolic blood pressure remained about 70 to 90 millimeters of mercury, and the diastolic pressure ranged between 30 to 50. Intermittent cessation of the levarterenol† caused an imperceptible blood pressure. The serum sodium concentrations increased from 118 to 125 milliequivalents per liter. On the sixth day after the onset of shock, her blood pressure stabilized at 110/70. At this time the serum sodium measured 135 milliequivalents per liter, and the blood urea nitrogen was 15 milligrams per cent. Her condition improved considerably. She became alert and bright. Her appetite was good. Several weeks later she made an uneventful recovery following ureteroureteral anastomosis on the right and cystoscopic dilatation of the left ureter which regained its patency.

Evidence of shock may be the only recognizable manifestation of acute sodium depletion. Apathy, weakness, nausea, vomiting, and particularly anorexia are prodromal signs. Orthostatic hypotension is significant. Increase in pulse rate, diminution in volume of the pulse, clammy skin, fall in blood pressure, shock, and coma ensue with progressive salt depletion.

The diagnosis of depletional hyponatremia rests upon an assessment of physical signs correlated with blood chemistry values. The history often discloses the predisposing factors incident to the sodium loss and substantiates the diagnosis. The intravenous administration of non-electrolyte fluids and diuretics and low salt diets are common contributory causes. A noteworthy example of serious urinary sodium loss is one produced by promoting vigorous diuresis by means of a large water intake following decompression of the urinary tract. The hyponatremia which occurs in such an instance becomes particularly dangerous when there exists renal tubular disease which impairs the sodium conserving function of the kidneys. When apparent dehydration and azotemia persist in spite of adequate fluid intake and urinary output a condition of hyponatremia is highly suggestive.

†In the form of Levophed® the Winthrop-Stearns tradename for their brand of levarterenol.

AN APPRAISAL of plasma volume and osmolarity of extracellular fluid is desirable in order to institute correct treatment. Elevation of plasma protein and hemoglobin concentrations, however, are not unequivocal indicators of plasma volume deficit. Decreased concentration of urinary chlorides as measured by the Fantus test is not always valid as an index of serum sodium concentration. The state of tonicity of extracellular fluid is established by measurements of plasma electrolyte concentrations. A practical approximation of normal osmolarity is made by the determination of serum chloride and bicarbonate concentrations, the sum of which varies between 125 and 135 milliequivalents. This applies in the absence of ketosis and renal insufficiency. A normal serum sodium concentration which is approximately equal to the sum of the chloride and bicarbonate concentrations plus twelve, also denotes normal osmolarity of the extracellular fluid. Thus, if an osmolar deficit exists, hypertonic electrolyte solutions are therapeutically indicated. If an increase in osmolar concentration of electrolytes is present, non-electrolyte fluids are required.

The pathogenesis of circulatory inefficiency due to hyponatremia is not well understood. It is difficult to ascribe the primary causative role of circulatory collapse to hypotonicity or to diminution of extracellular fluid. It has been shown that both plasma volume deficit and hypotonicity are required to produce shock due to hyponatremia, and that restoration of blood volume alone will not alleviate shock.[4] Loss of salt is more deleterious to the circulation than loss of water and the contraction of plasma volume is greater after salt depletion. Acute

salt depletion produces a decrease of plasma volume loss of protein from circulating plasma and a sharp decline of venous return, cardiac output, blood pressure, and circulation rate.[5] Acute water depletion with a comparable decrease in extracellular volume fails to produce this state of shock.

The physiologic effect of salt deficiency is a decrease in osmotic pressure of the extracellular fluid. As extracellular salt is withdrawn, water moves (in response to osmotic forces) out of the extracellular fluids into the cells. Excess water is excreted by the kidneys to restore tonicity of the extracellular space. Final result is extracellular dehydration, intracellular overhydration and hypotonicity of both compartments. Loss of circulating protein is not understood but may be accounted for by an extravascular segregation due to injury of the cells of the heart and blood vessels. When the sodium deficit becomes severe, the plasma protein osmotic pressure can no longer maintain intravascular blood volume. An inadequate "effective" circulating blood volume then develops. Death due to salt depletion ensues as a result of peripheral circulatory failure.

THE hemodynamic changes and the degree of circulatory inefficiency vary with the rate and quantity of sodium loss. A rapid depletion producing a serum sodium concentration of 120 milliequivalents is likely to cause shock whereas a slow depletion to the same serum sodium concentration may manifest meager symptoms. Rapid depletions occur from the gastro-intestinal tract, paracentesis and diuresis.

The renal excretion of large amounts of salt is physiologically regulatory insofar as elimination of excess salt and water is required to maintain homeostasis of body fluids. However, excessive rates of excretion of sodium salts beyond the point of physiologic adjustment is considered abnormal renal function. Following relief of urinary tract obstruction the kidneys may temporarily lose their capacity to conserve salt and water, and a variable period of time may elapse until this capacity is regained. This concept proposes a reasonable expectancy of possible grave depletion of sodium and water following decompression of the urinary tract.

Several processes probably contributed to the development of sodium depletion shock in the patient described above. Possible dialysis of the peritoneal cavity by urine eliminated *via* the abdominal sinus could deplete serum electrolytes. However the intravenous administration of electrolyte-free fluids producing considerable diuresis combined with an impaired capacity of the kidneys to conserve salt and water during the recovery phase of the obstructive uropathy contributed most to the occurrence of sodium loss.

The alleviation of circulatory collapse due to sodium depletion required restoration of normal osmolarity of the extracellular fluid. Isotonic saline accomplished this need slowly and not effectively until a considerable amount of isotonic saline was given. Hypertonic saline effectively and rapidly restores osmolarity and circulatory efficiency. Correction of the hypotonicity of the extracellular fluid and alleviation of shock could have been accomplished within several hours by means of hypertonic saline in the case herein described. A useful guide is the intravenous administration of 300 cubic centimeters of 5 per cent sodium chloride given over a period of several hours and re-evaluation of the patient.

SUMMARY AND CONCLUSIONS

1. A grave state of circulatory inefficiency results from severe hyponatremia due to sodium depletion. Shock persists until restoration of normal tonicity of the extracellular fluid is accomplished. The most effective means of alleviating this type of "medical shock" is by infusion of hypertonic saline.

2. Following decompression of an obstructive uropathy the capacity of the kidneys to conserve salt and water may be impaired. Ex-

5. Elkinton, J. R., Danowski, T. S. and Winkler, A. W.: Journal of Investigation 25:120 (1946).

cessive excretion of urinary salts rapidly depletes the body of an appreciable amount of sodium.

3. Intravenous infusions of non-electrolyte solutions which produce a considerable diuresis may induce serious hyponatremia and circulatory collapse.

4. The manifestation of shock may be the predominant sign of acute sodium depletion. The diagnosis of hyponatremic shock rests upon a careful evaluation of history, physical findings, and blood chemistry values.

5. An illustrative case is described wherein hyponatremic shock occurred during the recovery phase of intraperitoneal urinary extravasation.

425 Mt. Prospect Avenue

Organization for Congenital Deformities

The discovery that their baby has been born with certain congenital deformities such as hare-lip, cleft palate, webbed hands or feet, usually produces a grave psychic shock. This may even make parents incapable of establishing the proper home atmosphere so necessary for their infant's optimum growth and development. The services of a wise physician and understanding friends and relatives are particularly necessary at such times so that parents may find constructive outlets for their feelings of despair or guilt.

For this reason, parents have organized into the National Association for Rehabilitation and Reconstructive Plastic Surgery with offices at 701 High Street, Newark 2, N. J. This non-profit, non-segregated, non-sectarian, philanthropic association is devoted to the prevention, medical and social treatment, rehabilitation and research of such congenital deformities as hare-lip and cleft palate, or burns and deformities acquired through accident.

The immediate goal of this organization is to establish a service for parents of physically deformed children. This service includes visits from committee members to parents of such children (upon approval of the physician) in an effort to ease their minds with information about encouraging possibilities which plastic surgery now affords. These members may be able to call with the physician or the community public health nurse to persuade parents that these conditions are remedial.

An immediate objective of the organization is letting the public see that these children may be considered normal within the framework of their individual limitations. It will help parents accept these conditions and their possible limitations. To this end, the organization offers talks to groups and has an interesting program of factual, non-alarming instructional material. For further information, write to National Association for Rehabilitation at 701 High St., Newark 2, N. J.

Heart Disease Bibliography

A new publication in the heart disease field, *Selected References on Cardiovascular Disease*, has just been issued by the U. S. Public Health Service. This annotated bibliography will be of use to medical students, nurses, nutritionists, health educators, social workers, physicians and others concerned with cardiovascular disease.

References are arranged in sections according to major interests in the field, such as rehabilitation, emotional aspects, and patient education. Films are also listed in the 52-page booklet. Listed as Public Health Service Publication No. 472, it is available from the Superintendent of Documents, Government Printing Office, Washington 25, D.C., for 25 cents a copy.

URBAN J. FINNERTY, M.D.
Montclair

Injection Treatment of Hemorrhoids*

Present Day Concepts

A physician who has learned how to inject hemorrhoids can often bring swift and blessed relief to a patient. Dr. Finnerty here, in step by step fashion, shows how to do it—and tells when not to do it too.

FROM time immemorial, physicians and patients alike have sought a non-surgical means for treating hemorrhoids. Quacks and charlatans soon recognized and exploited the attractiveness of injection therapy. The medical profession, however, was slow to investigate and adopt sclerotherapy for hemorrhoids. Even today, much confusion exists. In many quarters, the procedure is thought to be questionable.

Properly used, injection therapy for internal hemorrhoids has much merit. It is not, however, a simple procedure and considerable care must be used in selection of cases. The doctor needs proper equipment and, above all, the technical skill to carry out the treatment successfully.

Hemorrhoids are arbitrarily classified as "internal, external and combined." There are three primary hemorrhoids, one on the left and two on the right side of the anal canal named by Myles in 1919 as the left lateral, the right anterior and right posterior hemorrhoids. The left lateral has three smaller secondary hemorrhoids, the right posterior has two secondary hemorrhoids and right anterior has no secondary hemorrhoids. *Their recognition is fundamental to the understanding of the subject.* Each primary hemorrhoid is divided into three distinct parts:

(1) The *pedicle,* which is in the rectum, is covered by pale rectal mucosa.Pulsations of a branch of the superior artery may sometimes be felt in the pedicle.

(2) The internal hemorrhoid which commences above at the ano-rectal ring and ends at the pectinate (dentate) line below. Covered by a red plum-colored mucosa, it lies inside the anal canal and is supported by the layers of the sphincter ani muscle.

(3) The external hemorrhoid which extends from the pectinate line in the anal canal to its rather definite border at the anus, is partly inside and partly outside the anal canal. The external hemorrhoid lies in the peri-anal space and is covered by two types of skin, the smooth glandless skin of the anal canal named by Gorsch the "anoderm" and the ordinary hair containing glandular skin of the anus. It is very sensitive to stimuli.

The *pedicle* and the *internal hemorrhoid* lie in the submucous space, an area insensitive to painful stimuli of burning and pricking but sensitive to distension as experienced in the injection treatment. The submucous space and the peri-anal space occupied by the hemorrhoid are separated by the intermuscular septum of the longitudinal muscle. This septum is all important in keeping the hemorrhoid in its place in the anal canal for it is attached to the anal canal lining between the internal and external hemorrhoid. When this muscle is well

*Read May 16, 1956 at the 190th Annual Meeting of The Medical Society of New Jersey.

developed and is acting efficiently a groove can be recognized on the surface of the hemorrhoid at the muco-cutaneous junction between the internal and external hemorrhoid. If the muscle attachment is absent, stretched or poorly developed, the groove is absent. This is characteristic of third degree hemorrhoids.

A description of the submucous and peri-anal spaces is necessary because of their importance in the injection therapy of hemorrhoids.

The *submucous space* contains the vessels of the pedicle and the internal hemorrhoid. The space is directly continuous above with the submucous space of the bowel; below it is separated from the peri-anal space by the intermuscular septum of the longitudinal muscle. It is into the submucous space that sclerosing solutions are injected and are free to spread.

The *peri-anal space* surrounds the anus. It is subcutaneous and contains the external hemorrhoidal plexus lying on the subcutaneous external anal sphincter. The intermuscular septum of the longitudinal muscle and the transverse septum which crosses the ischiorectal fossa together form the upper boundary of the peri-anal space separating it from the submucous and ischiorectal spaces above. Superficially the space is covered by skin and the corrugator cutis ani muscle and is exquisitely tender to pain and distension.

SELECTION OF CASES

IN SUITABLE cases, injection therapy may relieve symptoms for months or years and the patient may remain quite comfortable. It will stop hemorrhage in almost all cases of first degree hemorrhoids. It may be repeated if bleeding recurs. In many second degree hemorrhoids, in which only a moderate degree of prolapse occurs on defecation, satisfactory results may be obtained.

In more marked second degree and third degree hemorrhoids, surgery is the treatment of choice. Also, if hemorrhoids are complicated by fissure in ano, fistula, marked anal spasm, anal stenosis, thrombotic external hemorrhoids or mucosal prolapse, the most suitable method of treatment is radical surgery by means of which the hemorrhoids and the complications are corrected in one step. Exceptions to this rule are patients who are poor surgical risks because of severe medical problems or patients early in pregnancy.

TECHNIC

THE injection is made into the submucous space of the internal hemorrhoid or of its pedicle. If prolapse is the main symptom the pedicle should receive the injection. If bleeding is the main symptom, the internal hemorrhoid should be distended with the solution. Two or three of the primary hemorrhoids may be injected at the one time; the first injection is made at about the level of the ano-rectal ring which is demonstrated by withdrawing the anoscope from the rectum into the anal canal. Many types of needles and syringes have been advocated. The most useful is a ring Luer-Lok® 5 or 10 cubic centimeter syringe with a straight 20 or 22 gauge hemorrhoidal needle.

With the patient in the knee chest or inverted position a tubular anoscope of the Gorsch type is inserted. It is then withdrawn from the rectum to the anal canal. The first part of the rectum to prolapse into the speculum forming a ring of mucosa is the *ano-rectal ring*. The speculum is further withdrawn about one-half inch and pressure then exerted upward a little. This makes the hemorrhoids more conspicuous; the needle is now inserted obliquely through the rectal mucosa just above or at the level of the ano-rectal ring. It is inserted with a little jab and can be felt to pierce the mucosa into the submucous space. A sharp needle is necessary. As the solution is injected into the space bulging of the mucosa is noted. If the needle has not quite entered the space the mucous membrane will blanch; if the needle has been inserted too deeply into the muscle no bulging will occur. The solution squirts freely into the submucous space upwards onto the hemorrhoidal pedicle and downward into the hemorrhoid and around the anal canal to the secondary hemorrhoids. Its spread downward is limited by the intermuscular septum and so it does not enter the sensitive peri-anal space below.

A case record must be kept of the sites of the injection and amounts and kinds of solu-

tion used. Caution must be exercised in injecting previously injected areas. The anterior and posterior commissures are best avoided especially anteriorly, for an improperly placed injection may result in slough with recto-vaginal fistulization in the female or involvement of the prostatic capsule in the male.

A combination of therapy is often successful. I prefer to use 2 or 3 cubic centimeters of 5 per cent phenol in vegetable oil for the high submucous injections and 0.5 to 1 cubic centimeter of 5 per cent quinine and urea† for the intra-hemorrhoidal injections, especially near the pectinate line. It is preferable to use a smaller amount of solution for the initial injection to determine the tissue response. The quantity to be used subsequently can then be predicated upon the reaction to the previous injection. The hemorrhoids may be injected again at about two to three week intervals, this period being allowed for the resultant inflammation and its partial resolution.

An aseptic inflammation follows the injection with an immediate swelling of the hemorrhoid by the inflammatory products. Fibrosis and thrombosis of the blood vessel occur. The mucous membrane covering the internal hemorrhoids and pedicles is splinted to the underlying muscles and the submucous space is thus obliterated.

†I use Quinuride®, a product of the Acme Scientific Co., Richmond, Va.

RESULTS

IMMEDIATE clinical results are good. Bleeding often ceases at once and the pile pedicle becomes firm and fixed. Prolapse may be reduced or entirely controlled. Subsequently, however, resolution takes place and the symptoms may return. The long term results depend upon the degree of pathology and the diligence of the follow-up. The rate of recurrence varies from 10 to 20 per cent in first degree hemorrhoids, to 80 to 100 per cent in third degree hemorrhoids.

SUMMARY AND CONCLUSIONS

A REVIEW of the surgical anatomy, the criterion for the proper selection of cases, the technic and the results of injection therapy for internal hemorrhoids have been presented. The need for careful examination which must include a thorough sigmoidoscopy is obvious. The physician who first examines the patient bears a great responsibility in making the proper diagnosis. It is undesirable for the physician to treat anal or rectal disease until he has proved by all methods of examination that another more serious lesion such as ulcerative colitis or cancer does not exist. It will do little good for the public to be cautioned to seek early medical aid if the physician fails in his responsibility to make an adequate examination.

100 Park Street

Medical Aspects of Highway Accidents

Highway slaughter could be materially reduced by use of seat belts. Such devices should be anchored to the frame of the car and not to the seat. High speed hypnosis and fatigue are important causative factors in automobile accidents. Another is diminution of the field of vision with increased speed—a phenomenon long recognized by Air Force personnel but rarely appreciated by automobile drivers. Normally, the peripheral vision is 180° when a person is walking. At 20 m.p.h. it is reduced to 104°, at 40 m.p.h., 70°, and at 60 m.p.h. it is slightly over 40°. Add to this the effects of smoking, fatigue, night driving, tinted windshields and tinted glasses, and the driver merely becomes the occupant of a missile."

—C. L. Marsh and R. C. Moore in the South Dakota Medical Journal, 8:103 (1956)

James W. Robinson, M.D.

Summit

Theodore R. Failmezger, M.D.

Madison

Gout in 1956*

Within a decade or two, write Doctors Robinson and Failmezger, it should be possible to eliminate tophaceous gout. This desideratum, they suggest, will be achieved by combinations of probenecid, new phenyl butazone derivative and colchicine.

A discussion of gout is especially timely. Knowledge which was scanty for centuries, is now being elucidated by atomically labelled chemistry. We now have a good uricosuric agent. Gout, like all chronic diseases, will be on the increase in our aging population. A century ago, the use, or abuse, of fermented liquors was widely accepted as being the most important predisposing cause of gout. But we know now that 30 per cent of gouty patients are total abstainers. A century ago, uric acid was believed to be the culprit when hyperuricemia was demonstrated and tophi were known to consist of uric acid. However, in the last 40 years, the finding of hyperuricemia in members of gouty families who do *not* have gout, and the demonstration that gout *cannot* be produced by intravenous injection of uric acid, cast doubt on this etiology. It is now felt that some purine or purines other than uric acid are responsible for acute gouty arthritis.[1]

Gout has been described as an inborn error of metabolism in which the blood uric acid is elevated and which is associated with acute recurring attacks of monarticular synovitis. Something protects the male before puberty and the female before the menopause from hyperuricemia. This disease which is characterized by variable periods of asymptomatic hyperuricemia, is eventually complicated by recurring attacks of acute synovitis or arthritis, usually monarticular. In severe and prolonged cases, urate crystals are deposited in various tissues, thus beginning the stage of chronic tophaceous gout.

The metabolic defect of gout is gradually becoming better understood with atomically labeled isotopes. We can now measure the total amount of uric acid within an organism, and the concept of the "total metabolic pool" has emerged. Normally, this pool of uric acid measures one Gram. About 75 per cent of this is excreted each day and is replaced by newly formed uric acid. In the gouty patient, this pool is usually two Grams [2] and may reach 30 Grams. An unusually large miscible pool of uric acid is found in certain other conditions, notably leukemia, thus accounting for "secondary gout."

*Presented before the Section on General Medicine, Annual Meeting of The Medical Society of New Jersey, May 16, 1956.

1. Gutman, A. B. and Yii, T. F.: American Journal of Medicine, 13:744 (Dec. 1952)

2. Talbott, J. H.: Journal of Chronic Diseases, 1:338 (March 1955)

GRANTED then, that the gouty subject seems to be blessed with more than his share of uric acid, we may well ask, "how did this come about?" It was formerly thought that all this excess uric acid represented a degradation product of nucleoproteins, derived either from ingested cellular nuclei or from cells broken down in normal catabolic processes. Accordingly, much emphasis was placed on the necessity of the low purine diet.

However, by using glycine identified by the presence of isotopic nitrogen, it can be shown [1] that some gouty subjects have the peculiar ability to synthesize uric acid directly. They take what might be called a silly short cut, and for no useful reason produce urates from simple precursors without going up the ladder and down the ladder of nucleoprotein metabolism. This quirk would lead one to expect that the gouty subject would tend to excrete more uric acid than normal, regardless of his diet.

About 6 per cent of gouty subjects, apparently due to renal damage, excrete less than the normal amount of uric acid. Yet 33 per cent of gouty patients do excrete more than normal. Urates are distributed throughout the other body fluids as well as the blood. Gout is thus not only a disease of the joints. When the saturation point is reached, urate deposition occurs not only around the joints, but also in other tissues, including the kidneys. It is not unusual for mild albuminuria to occur with hyperuricemia before the occurrence of acute arthritis. There is a tendency for the physician to look with kindly awe and pity at the obviously deformed extremities of the patient with tophaceous gout. But the unseen kidneys are much more vital to the patient's health. While his painful hand and feet will never kill him, his kidneys decidedly can.

DIAGNOSIS

THE first step in the diagnosis of gout is to think of it. More than one patient with gout has hobbled to a second physician because the first one was treating him for cellulitis or injury. The typical attack may be diagnosed with considerable accuracy by telephone or by your next-door neighbor. But gout should be suspected in any arthritis of *sudden onset.* This is the most characteristic single feature. Suspicion should be especially keen if only one joint is involved; particularly in the big toe or elsewhere in the lower extremity, if the patient is a male, is obese, has visible lesions resembling tophi, has a history of a previous attack followed by complete recovery, or has a family history of gout.

The diagnosis of tophaceous gout should be quite easy. The acute attacks are so painful that it is unlikely that a patient will be undiagnosed by the time he has developed tophi. The diagnostic interest of the clinician focuses more on the acute attack, particularly the initial attack. Any acutely painful arthritis, a husky red-faced male with prematurely gray hair, hobbling into your office with a cane, shiny red, tense skin over the involved joint, with subsequent desquamation—all are suggestive features. Occurrence of the attack a few days after an operation, hunting trip, alcoholic binge or unaccustomed strenuous exertion is frequent.

Questioning may reveal a previous history of sudden arthritis not diagnosed as gout. X-rays are generally not helpful diagnostically, although more or less characteristic punched-out areas do occur later, below the articular surfaces of involved joints. The sedimentation rate is usually elevated, but is of no real help.

A patient in acute pain is interested primarily in immediate relief, and any good doctor would, of course, aim at relief of pain as his first goal. But concern for the patient's future health demands that gout be proved or disproved if possible when first suspected. Accordingly, blood should be drawn for uric acid determination as soon as possible, before giving any treatment such as aspirin which may obscure the picture. A few doses of codeine or other strong anodynes are justifiable. This will not lower the serum uric acid, and will facilitate the correct diagnosis of the initial attack. This, plus the therapeutic trial of the specific drug colchicine will clinch the diagnosis.

The need for accurate diagnosis is also ap-

plicable in secondary gout. This occurs in some hematologic disorders including leukemia, Hodgkin's disease, pernicious anemia, polycythemia, and multiple myeloma. It is thought to be due to the abnormally high rate of nucleic acid breakdown.[3] Since the acute attack may be indistinguishable from primary gout, it behooves the physician to recognize not only the acute arthritis but also the underlying disease.

TREATMENT

PRECLINICAL gout, or hyperuricemia in gouty families, requires no treatment. However, close observation is advisable, since these people may develop gout at any time. Talbott [2] has demonstrated a gradually increasing uric acid beginning in childhood, and has observed acute gout occurring for the first time in a man of 81, who was known to have hyperuricemia for three years.

Acute gouty arthritis presents to the physician one of his most rewarding opportunities to behold that satisfying phenomenon, the grateful patient. General measures include rest, elevation of the affected joint, and the application of moist heat. More or less specific measures include the steroids, phenylbutazone, cinchophen derivatives, and colchicine. Even in this fast-moving twentieth century, we feel that colchicine (first used in 550 A.D.) remains the drug of choice for the acute attack, for several reasons: lack of expense, specificity when diagnosis is not sure, lack of serious side effects, and few contraindications. This makes self-treatment safe, effective, and desirable. Enough should be given to cause mild gastrointestinal toxicity or relief of symptoms. A limit of about five to seven milligrams should be set, since death has been known to occur after unqualified orders. A representative scheme [4] is 0.5 milligrams (1/120 grain) every hour until relief of pain or nausea or diarrhea occur. Intravenous colchicine is available for the rare patient who cannot tolerate enough orally to be effective, and perhaps better is a newer preparation, Colcemid®, which has been reported less irritating to veins.[5]

There are a few patients who do not respond or become refractory to colchicine. For these, phenyl butazone‡ is probably the drug of choice, in the absence of contraindications. A suggested dose is 400 milligrams followed by 200 milligrams every four hours for two or three days, or a smaller dosage if effective.

ACTH is probably the next drug of choice in the treatment of the acute attack. One hundred units of the Corticotropin or 40 units of Cortrophin®-Zinc† intramuscularly each day until relief is obtained, followed by decreasing doses for two or three days, and accompanied by colchicine 0.5 milligrams two or three times daily to prevent rebound exacerbations, is an expensive but effective form of treatment.

As to the other steroids, cortisone in all its variations and chemical forms, orally, intramuscularly, or intra-articularly, is generally not satisfactory. Cinchophen and neocinchophen, while their toxicity may have been unduly stressed in the past, have been practically replaced by the other drugs mentioned.

Whatever form of treatment is found best for the individual patient, one course may or may not be enough to give lasting relief. A second course may be advisable in a few days. Some patients with experience also learn to recognize the symptoms of an impending attack, which with oral therapy, particularly colchicine, may be warded off very safely and satisfactorily, on a dosage schedule of 0.5 milligrams four times daily for two or three days.

After the attack has subsided, some decision as to future measures must be made. How much a patient can be or should be expected to modify his entire life should depend on intelligence, cooperativeness, height of serum uric acid level (perhaps), and frequency of

†Corticotropin is available under the registered Organon tradename of Cortrophin Gel®.

‡Phenyl butazone is commercially available under the Geigy tradename of Butazolidin®.

3. Kuzell, W. C. *et al.*: Journal of Chronic Diseases, 2:645 (Dec. 1955)

4. Locke, L. M.: Bulletin of Rheumatic Diseases, 6:3 (Nov. 1955)

5. Kuzell, W. C. *et al.*: Archives of Internal Medicine, 96:153 (August 1955)

past or future attacks. Frequent attacks demand vigorous treatment.

If there has been only one attack, no interval treatment may be necessary. If there have been numerous attacks, especially if the uric acid is high, all the available means to attempt to reduce attacks are indicated. This includes a low purine diet (at least some limitation may be advisable), prophylactic colchicine, 1 milligram a day, avoidance of alcoholic excesses, weight reduction (if the patient is obese) and, perhaps, probenecid.*

THE tophaceous stage of gout begins with the development of tophi. This does not occur exactly at a certain clear-cut point of time. Tophi exist, either microscopically, or macroscopically before they are clinically recognized. Once tophi are known to exist, however, either subcutaneously or as punched-out bony lesions, attempt should be made to eliminate them by promoting the excretion of uric acid.

In large doses, salicylates do have some effect as uricosuric agents. They are certainly worth trying if probenecid* is not tolerated or if phenyl butazone is contraindicated or not tolerated.

With the introduction of propyl sulfamyl benzoic acid (probenecid*) in 1949, the therapeutic possibilities of promoting uric acid excretion were revolutionized.[6] Probenecid* acts in the renal tubule where it decreases reabsorption of uric acid. It increases the output of uric acid by 30 per cent in most patients. Fortunately the toxicity and side effects are slight. Here, then, for the first time is a drug that seems tailor-made for the purpose of shrinking the enlarged metabolic pool of urates in the patient with gout. Its effectiveness has been proved repeatedly, and there is reason to believe that within a decade or two, it should be possible virtually to eliminate chronic tophaceous gout as we see it today. Serum uric acid levels are lowered in time to normal or near-normal levels. Attacks of acute synovitis are usually decreased, and there is even evidence that renal insufficiency may be improved, to the extent that it is due to urate deposition in the renal parenchyma.[7]

The dose of propyl sulfamyl benzoic acid* (probenecid) is usually 1 Gram daily, with a smaller dose initially in some cases, or a larger maintenance dose in a few. Many patients have been taking it for over five years continuously, with relatively minor toxic effects reported, in only seven to eight per cent of cases. When you give probenecid,* warn the patient that an acute attack of gout may be precipitated. About one in ten patients have this experience soon after starting the drug. The reason for this has not been clear, but treatment with colchicine is effective, and then probenecid* may be continued.

Urinary calculi may be produced at the beginning of this therapy, due to the tremendous increase in mobilization of uric acid from tissues and body fluids. This may be minimized or prevented by three measures: (1) keeping the dosage as low as possible for effective uricouresis; (2) forcing fluids; and (3) alkalinizing the urine, especially during the first few weeks.

Salicylates should not be given concurrently with probenecid, since the uricosuric effects of the two drugs may neutralize each other.

Phenyl butazone‡ has considerable uricosuric action. This is not comparable to that of probenecid* except in high dosage, and it would not be justified in most cases. However, excellent results[3] have been obtained with phenyl butazone‡ in chronic tophaceous gout that is otherwise hard to control, and with a dosage of only 100 to 300 milligrams daily. Much investigative work[8] is now in progress on the problem of developing phenyl butazone-like compounds[9] with less toxicity. There are some promising tentative results and if this field of research is fruitful, we may well have even more tools at our command to manage this previously unsatisfactory disease.

*Probenecid is commercially available under the Sharp and Dohme tradename of Benemid®.

6. Boger, W. P. and Strickland, S. C.: Archives of Internal Medicine, 95:83 (January 1955)

7. Phillips, R. W.: Archives of Internal Medicine, 96:823 (December 1955)

8. Brodie, B. B. *et al.*: Proceedings of the Society for Experimental Biology and Medicine, 86:884 (September 1954)

9. Weiner, Maximillian: Personal communication to the authors.

Death in gouty subjects is usually due to circulatory disturbances.[3] Insurance companies are now recognizing that life expectancy with gout is nearly normal.[2]

SUMMARY

1. It was once taught that pharmacologically inert uric acid was the cause of gout. Current concepts of its pathogenesis are much more dynamic. Atomically labelled compounds are dislodging us from our older and more complacent concept.

2. Most cases of gout can be handled by a combination of 1400-year old colchicine and six-year old probenecid.* Phenyl butazone is also useful in cases of gout otherwise hard to control.

129 Summit Avenue

Surgical Removal of Normal Tissue

"The removal of normal tissue cannot automatically brand an operation as unjustified," said Dr. Robert S. Myers, writing in *Hospitals,* for June 1956. Dr. Myers gave two reasons to support his statement. He said, "medicine is not an exact science, and it is frequently not possible to make a positive and accurate pre-operative diagnosis." Also, he observed, "the indications for a specific surgical procedure frequently require the removal of known normal tissue."

A research project of the American College of Surgeons found that "in the most competent hands the pre-operative diagnosis of 'acute appendicitis' was confirmed in only 83 per cent of a series of cases in which the operation was justified in 97 per cent." The ratio of normal tissue removed to the total number of surgical procedures done "in appendectomies for acute appendicitis, sometimes exceeded 15 per cent. The rate for unjustified surgery in this series, however, was only 3 per cent." In another series, the normal tissue rate was 45 per cent, "yet the justified hysterectomy rate, as determined by judicious physicians, was 100 per cent."

"It is not logical to lump together all tissues, including normal tissues removed incidentally to some other surgical procedure, to arrive at a single normal tissue rate for all operations. A normal tissue rate is not the sole criterion of the justification for surgery. This can be determined only by the physicians' evaluation of the clinical indications for surgery in each case."

Dr. Myers pointed out that "the pathologist's diagnosis alone is not the yardstick of the justification for surgery; a pathologist's diagnosis of abnormal tissue in no way guarantees that such tissue was removed justifiably."

He observed that "there are still a few physicians and hospital administrators who fail to recognize that clinical indications must determine the justification for surgery; their persistence in the illogical and erroneous belief that normal tissue removal and a normal tissue rate based on this removal are the sole evidence of unjustified surgery has hampered the intelligent and effective operation of some tissue committees."

The French Have a Word for It

The French word for "dandelion" is *pissenlits.* The flower has been used for 500 years as a diuretic. The yellow color is proof that the bitter root has diuretic properties. "Lit" is the French word for "bed."

Louis Grunt, M.D.
Newark

Early Course of Juvenile Diabetes*

Juvenile diabetes is not diabetes in young people. It is diabetes in thin people who need large amounts of insulin. This disease is attended by a booby trap: a swift, early remission which may delude the doctor into thinking that the patient is under good control. He isn't.

Early in the course of juvenile diabetes, patients often improve markedly and develop false hopes of "cure." This can prove to be a poignantly tragic blunder unless all concerned are alerted to the danger of remission. Here is how Wilder [1] puts it:

"Transient remission of intensity is characteristic of the early diabetes of children and young adults provided some treatment is given. At this time the treatment may be far from perfect—indeed, in some cases all that is required to control the glycosuria may be some simple dietary. The patient or parents are overjoyed, the physician is pleased, but the hope aroused is false. In the course of a few months or in a year or two the intensity of the disease again increases and then to omit adequate treatment is to invite a tragedy. It is important to warn patients, and if they are children, the parents, to avoid being lured into a false sense of security by the early benign course of diabetes. Even with the exercise of the greatest possible efforts to maintain a normal blood sugar, later exacerbation, necessitating the use of insulin, is to be expected in almost all cases of diabetes of the young."

I now wish to report on a study of 18 juvenile diabetics in an office practice who were followed closely enough, or who were reliable enough, to give an accurate history of the early stage of their disease.

Ages varied from 5½ to 48 years. It would seem appropriate at this point to explain what is meant by "juvenile diabetes." Juvenile diabetes is diabetes in thin patients who need larger amounts of insulin and tend to "brittleness" in control. Age is a secondary consideration. The average age of this group of patients was 23. Ten of the 18 were males. There was no significant difference between weight at onset of the disease and weight during amelioration.

Most noteworthy was the almost uniform reduction in the amount of insulin, if one compares the amount needed to control the diabetes at the onset of the disease and the amount needed during the remission. The average dropped from 37 units to 9 units. Of especial interest was the number of patients (9) who were able to get along for varying periods without any insulin at all. The remission occurred within 3 weeks to 23 months after onset of the disease and averaged 6½ months. Duration of the remission was frequently short-lived (6 weeks, *e.g.*) and occasionally prolonged (23 months). The average duration of the remission was 5 months.

These patients were treated with liberal, but fixed, amounts of carbohydrates, usually between 180 and 250 Grams daily. An effort was made to see that they consumed at least 60 to 120 Grams of proteins daily and that enough fat was supplied to maintain weight at near normal levels as determined by the usual height-weight charts. Insulin was used to control glycosuria rather than the blood sugar.

*Read on May 16, 1956, before the Section on Metabolism at the 190th Annual Meeting of The Medical Society of New Jersey.

Glycosuric patients were treated with insulin. Insulin was not used merely to lower the blood sugar.

One case is of special interest:

In 1939, a 22-year old girl was seen at the onset of her diabetes. After 4 months treatment with diet and insulin the blood sugar, both fasting and postprandially, became normal. Hope of a cure was aroused. A glucose tolerance (Exton) test was done and yielded the following figures: 96, 190, 166. Within three days the patient returned to the office with marked glycosuria and a fasting blood sugar of 280. It has since been considered unwise to do glucose tolerance tests during the remission.

Diabetes is not a static disease. Many factors cause exacerbations and remissions. Obesity has a high correlation with insulin needs. Many obese diabetics when reduced to normal weight show not only normal blood sugar values but even demonstrate a normal glucose tolerance. None of our patients showed significant weight fluctuation between onset and remission. Disease of the endocrine glands (such as, Cushing's syndrome, acromegaly, pheochromocytoma, hyperthyroidism and disturbance in gonadal function) can impair glucose tolerance. Less clearly understood is the relationship between disturbed glucose tolerance and the hypothalamus. The alleged relationship between blood sugar and certain types of brain surgery and brain trauma has not been confirmed.[3] Diseases of the liver, especially hemachromatosis are occasionally involved in diabetes. None of these factors could be found as an influence in the ebb and flow of diabetes as manifested in these patients.

Stress, whether infectious, traumatic or emotional can aggravate diabetes. Presumably such a phenomenon would take place through the anterior pituitary and the corticosteroids. However, the evidence here is contradictory. It has been shown that the excretion of formaldehydrogenic steroids is low in over half the diabetics studied. Yet, during adequate diabetic control the steroid levels are usually lower than when poorly controlled but not in acidosis. The failure of a uniform increase of steroid secretion to occur during stress has been confirmed. Joslin[8] has demonstrated a tendency towards increased ketosteroid excretion in diabetic children over normals, and a tendency towards subnormal levels after 10 years of diabetes.

It would seem that some definitive work is needed in this area. Serial steroid excretion studies done at the onset, during the remission and the ultimate aggravation of the disease might throw further light upon this relationship.

THE connection between growth hormone of the anterior pituitary and diabetes is still confused. Children frequently grow excessively just before the onset of diabetes. McCullagh *et al.*[10] recently marshalled impressive evidence for this relationship, although the authors could not explain the failure of many acromegalics to develop diabetes.

So little is known about "Insulinase"[11] and Glucogen[12] that it seems futile to attempt a correlation with the remission under discussion. Lukens and Dohan[13] and Haist, Campbell and Best[14] showed that in partly depancreatized animals treated with anterior pituitary extract diabetes with hydropic degeneration of islet tissue could be induced and that by treatment either with insulin or a high fat, low carbohydrate diet, regeneration of islet tissue could occur. As a result the remission in early diabetes is usually assigned to a similar change taking place clinically. Against this view is the finding of Warren[15] that hydropic degeneration was found only rarely in human postmortem material but that if pancreatic tissue was left at room temperature for 8 or 9 hours such changes were very frequent. Considering that the patients being presented were not treated with a high fat low carbohydrate diet, and that no attempt was made to keep the blood sugar at normal levels with insulin, it can be said that such a concept is not borne out clinically. Half of our patients were able to get along without any insulin for varying periods of time.

Colwell[1] and Jackson[7] have advanced the concept that diabetes is present from birth and not just when hyperglycemia occurs. Colwell has further stated that at first there is an amelioration of the diabetes but as time goes on the condition becomes steadily more se-

vere. It is my impression that this is true only within certain limits—that eventually a steady plateau is reached which is held fairly steadily, subject to various influences previously discussed. Terminally, as judged by insulin needs, Zubrod *et al.*[16] and Runyon *et al.*[17] have shown that there is a progressive decline in insulin need as the kidney lesions of diabetes become clinically apparent.

A clinical picture of the insulin needs in diabetes could be schematically visualized. We would see that, at first, the diabetes tends to be severe, usually followed by a remission lasting from only a few weeks to a year or more. This phase is followed by gradually increasing dosages of insulin. The pattern of insulin need during this period is not well delineated. Terminally, there is frequently marked falling off of insulin requirements. What factors are at work producing the long range fluctuations in insulin dosage remains unexplained. One can call this cyclic change "the natural history" of diabetes, but this throws no light on the mechanisms involved. It would seem advantageous to recognize the patterns of change that are seen clinically and to admit that the reasons for the fluctuations are unknown.

CONCLUSIONS

1. There is an almost uniform remission early in the course of juvenile diabetes mellitus occurring on the average of 6.7 months after the onset of the disease and lasting an average of 5.2 months. Of 18 patients, 9 were able to get along for varying intervals without any insulin at all.

2. There is no satisfactory explanation for the remission. The most promising avenue of approach would seem to be more intensive study of adrenocortical steroids as related to the remission.

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A bibliographic reference list appears in Dr. Grunt's reprints.

Green Light for Artificial Sweeteners

There is no evidence that use of artificial sweeteners, saccharin and the cyclamates for dietary purposes is hazardous, according to the A.M.A. Council on Foods and Nutrition.*

Clinical studies of the biologic effects of saccharin revealed no significant harmful effects upon consumption of up to 1.5 Grams per day for periods varying from two to five months. Laboratory investigations of chronic toxic effects of saccharin in rats corroborated the findings that the sweetener is relatively non-toxic.

Studies of the cyclamates have revealed no significant adverse effects at 1 per cent of the diet or less. At 5 per cent of the diet, studies in laboratory animals showed slight toxic effects, including moderate diarrhea.

In healthy men the only observed adverse effects of cyclamate has been softening of stools at intakes of 5 Grams or more per day. However, this "seems to be without hazard to health."

The report emphasizes that experience with the use of cyclamate is more limited than with saccharin, and continued study of the cyclamate is required to determine safe dosages for children and its use in pregnancy and the like.

This report gives a reassuring appraisal of the safety of these sweeteners for special dietary purposes but does not support the unrestricted use of these sweeteners in general purpose foods and beverages.

*Council on Foods and Nutrition: J.A.M.A. 160:875 (Mar. 10) 1956.

Donald J. Kissinger, M.D.

Frank R. Begen, M.D.

Teaneck

The Johnson-Lowsley Operation for Urinary Diversion*

When the bladder must be removed, the urinary stream must be diverted. Many ingenious plans have been developed for effecting this diversion. In the hands of Dr. Begen and Dr. Kissinger, the Johnson-Lowsley operation has been superior to all other methods.

In an effort to eliminate the scientific and social complications often associated with urinary diversion, Johnson and Lowsley[1] devised the operation called "neocystoproctoplasty." As the name implies this consists of the formation of a new bladder and a new rectum. The five steps to the operation are:

1. Isolation of the ureters with or without cystectomy.
2. Selection of the anastomotic sites for the ureters and transection of the sigmoid.
3. Formation of the new bladder.
4. Mobilization of the proximal sigmoid.
5. Formation of the new rectum.

A complete description of the surgical technic will be found in Johnson and Lowsley's original article.[1] The basic principles of the operation are: (a) the use of the rectum, as a blind pouch, to form a new bladder, and (b) the creation of a new rectum by pulling the proximal sigmoid down in front of the new bladder but under the external sphincter. This affords urinary and fecal continence both under the control of the anal sphincter.

Since the pioneer work of Lloyd[2] in 1851 and Simon[3] in 1852, there has been an unending search for a good method of urinary diversion. The most popular procedures today are the cutaneous ureterostomy and the ureterosigmoidostomy. Boyce and Vest[4] describe an operation utilizing the isolated rectum and pelvic colon to make a new bladder, combined with a colostomy. There are objections to all of these procedures. The cutaneous ureterostomy is often complicated by ascending infection with pyelonephritis and excoriation of the skin. It is always complicated by the objectionable odor and the necessity of wearing an appliance. Ureterosigmoidostomy, in spite of its numerous and ingenious variations, still produces a high incidence of hydronephrosis, pyelonephritis and hyperchloremic acidosis.

With the voluntary control of urine and feces, the main objection to urinary diversion from the patient's viewpoint, is eliminated. The psychologic impact of colostomy and urinary

*Read May 17, 1956, at the Annual Meeting of The Medical Society of New Jersey. This work is from the Holy Name Hospital in Teaneck.

1. Johnson, T. and Lowsley, O. S.: Journal of Urology, 73:83 (1955)

2. Lloyd, Mr.: Lancet, 2:370 (1851)

3. Simon, Sir J.: Lancet, 2:568 (1852)

4. Boyce, W. H. and Vest, S. A.: Journal of Urology, 67:563 (1952)

bags, with attending odor, should not be underestimated. We have all known patients who preferred to keep their disease, or die, rather than wear such devices. This attitude has cost many lives. If patients can be assured of continence, or at least the lack of collecting appliances, more will submit to necessary surgery.

With neocystoproctoplasty, some enuresis is encountered in the immediate postoperative period. In our series, all except two with extensive malignant growths and marked debility, developed complete urinary control. Bladder capacity is from 300 to 350 cubic centimeters and frequency varies from every three hours to every six hours. Complete fecal continence has not been obtained in all cases. However, those whose fecal control is incomplete have found that a daily morning enema eliminates accidental loss and the necessity of wearing a bag.

FROM the physician's standpoint hydronephrosis, pyelonephritis, and hyperchloremic acidosis present the most disturbing problems. In a review of 2897 cases of ureterosigmoidostomy comparing the muscularizing operation, the tunnel operation, the direct anastomosis, and their own combined operation, Clarke and Leadbetter [5] found an average of 49 per cent of hydronephrosis, 30 per cent of pyelonephritis and 42 per cent of hyperchloremic acidosis.

The average intravesical pressure is 8 to 10 centimeters of water,[6] and the average intrarectal pressure (resting) is 27 centimeters of water. During micturition the intravesical pressure rises to 130, whereas the intrarectal pressure may rise to 270 during defecation.[7] Therefore, hydronephrosis was expected with the neocystoproctoplasty. Surprisingly, hydronephrosis was uncommon in our series. No exact percentage figures are available at this time. Hydronephrosis, although encountered, was not considered a complication because of its sterile nature. To date it has not been troublesome. Longer follow-ups may prove it to be responsible for some complication not yet obvious.

In our series not one case of clinical pyelonephritis has been encountered. Two patients showed grossly infected urine and ran a septic postoperative course, but both responded promptly to urinary antiseptics and the infection did not recur. To avoid this complication pre-operative bowel sterilization is accomplished by the method described by Poth.[8] Beginning 20 hours pre-operatively Neomycin® and Sulfathalidine® are given by mouth. One hour before operation, a 1 per cent Neomycin® solution is instilled as a retention enema. Cultures taken from the new bladder at operation consistently showed no growth.

Acidosis following ureterosigmoidostomy occurs because of a combination of factors. In the presence of pyelonephritis and obstruction, renal tubular decompensation results in retention of sulfates and phosphates.[9] More important is the direct re-absorption of the chloride ion from the bowel, predominantly as the ammonia salt.[10] In the neocystoproctoplasty where there is no pyelonephritis and little or no re-absorption from the pelvic colon,[11] hyperchloremic acidosis does not occur.

TO DATE 17 such operations have been performed, all for vesical malignancy. Ten were done at St. Clare's Hospital, New York City, and seven in Holy Name Hospital, Teaneck, N. J. Mortality rate in this series compares favorably with other methods of diversion. This is especially true when it is considered that all the patients had cancer and the first cases were reserved for advanced disease. There were three operative deaths for a mortality rate of 17.7 per cent. The third, fourth, and fifth patients died within three weeks of opera-

5. Clarke, B. G. and Leadbetter, W. F.: Journal of Urology, 73:999 (1955)

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7. Hurst, A. F.: *Constipation and Allied Disorders.* London: Frowde (1919)

8. Poth, E. J.: Journal of the American Medical Association, 153:1616 (1953)

9. Dennis, W. and Hobson, S.: Journal of Biol. Chem., 55:183 (1923)

10. Boyce, W. H. and Vest, A.: Journal of Urology, 67:169 (1952)

11. Boyce, W. H.: Journal of Urology, 65:241 (1951)

tion. Death was due to peritonitis, saddle thrombus, and coronary thrombosis in that order. The first two patients are alive and well 34 and 33 months postoperatively with no evidence of metastasis.

Many complications were anticipated but so far few have occurred. Those worth mentioning were prolapse of the new rectum in two cases and ruptured diverticulitis in two cases. The only two with diverticulosis resulted in ruptured diverticulitis. This suggests that diverticulosis is a contra-indication to the procedure and a colostomy probably should be done when it is found.

To show how neocystoproctoplasty can return a debilitated patient to full activity, the following case is presented:

A 56-year old man was admitted to Holy Name Hospital with an excoriated suprapubic cystotomy. Three years before admission a segmental resection had been done for transitional cell carcinoma of the bladder. Two years before admission a suprapubic fulguration was performed followed by intensive x-ray therapy for recurrent tumor. The result of this treatment was a permanent suprapubic cystotomy, and a contracted bladder with a capacity of only 30 cubic centimeters. From that time until his admission, the patient remained at home with a draining, irritated wound.

Three days after admission, a neocystoproctoplasty was performed. Twelve days later, he eviscerated and was repaired. After a stormy course marked by persistent vomiting, the patient was discharged in good condition 48 days after the primary operation. The suprapubic and abdominal wounds were well healed and the patient had good control of both urine and feces.

On admission blood urea nitrogen was 13 milligrams per cent; serum chlorides were 690. At discharge, blood urea nitrogen was 19 and serum chlorides 620. Intravenous pyelogram on discharge showed good function on both sides with no evidence of hydronephrosis.

Fourteen months after operation, blood urea nitrogen was 19 and serum chlorides were 625. Serum sodium was 148, serum potassium 5. Pyelogram again showed good function in both kidneys with no evidence of hydronephrosis or other structural changes.

Two months after discharge this patient was able to return to his business full time. In this case the neocystoproctoplasty had converted an incapacitated individual into an active breadwinner.

This operation is not offered as a cure for cancer. It should be considered in all cases where permanent urinary diversion is indicated. Even in the face of a hopeless prognosis the palliation afforded often makes the operation worthwhile. As the technic and results have steadily improved, we have felt justified in offering the operation earlier to our cancer patients.

CONCLUSIONS

1. Neocystoproctoplasty is the best operation we now have for urinary diversion, in terms of both its social and medical results.

2. This operation is not a cure for cancer but should be considered in every case where permanent urinary diversion is necessary.

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Shoe-Fitting X-rays

Shoe-fitting fluoroscopy should be discontinued, warns Dr. L. I. Gardner* of the State University of New York. This x-ray procedure may be particularly hazardous for children.

Virtually every recommendation made for the limitation of radiation exposure is omitted in the use of this device. Machines often are poorly shielded and permit excessive leakage. The duration of the examination is prolonged by the interest of the child and the parents. It is yet to be demonstrated that shoes cannot be equally well fitted by palpation of the foot through the leather.

*Gardner, L. T.: Shoe-fitting fluoroscopy, a problem of gadgetry in modern life, Current Medical Digest, 23:55 (May) 1956

Isador Ripps, M.D.

Plainfield

Hay Fever*

Satisfactory results in 75 per cent of the patients are reported in this study of the treatment of hay fever. All the suggested etiologic factors, except emotional ones, are reviewed, and all recommended treatment technics except psychotherapy are evaluated in this compact monograph.

Hay fever, or seasonal allergic coryza, affects more than 3,500,000 people in the United States, about 2 per cent of the population.[1] It is a specific disease caused by hypersensitivity to pollen, particularly ragweed pollen. However, other factors, either as sole exciting agents or as excitants complicating pollen hypersensitivity, may be operating to produce the coryzal symptoms which we associate with this disorder. In a broader sense hay fever might be considered a seasonal syndrome, with ragweed pollen as the sole major cause in the production of symptoms in *most* patients, but with other etiologic agents causing the same type of symptoms in other patients either during the pollen season or immediately after the season is presumably ended. Non-pollen excitants may include molds, seasonal foods, specific environmental dust, insect debris, products of infection and allergens that may be spread by burning leaves and windblown decaying leaves. Non-specific excitants such as fatigue, irritating chemical fumes and household heat may also contribute to the seasonal and post-seasonal symptoms. These specific and non-specific factors must be given due consideration.

DIAGNOSIS

Accurate diagnosis depends not only on a thorough knowledge of the possible etiologic factors, but also on good history taking, skill in the performance and interpretation of skin tests, and, when indicated, certain x-rays and laboratory examinations.

Pollen Seasons: Pollens begin to appear about the end of March and continue through September, with but a short period of freedom from about mid-July to mid-August. The most important pollens producing hay fever symptoms are air-borne. They are blown by the wind over wide stretches of territory. Tree pollens fill the air from March to early May. Ash, beech, birch, elm, hickory, maple, oak and poplar are the most important trees in the East. Oak seems to be the most significant because it is so widespread. A patient with a history of recurring coryzal symptoms at this time of the year should be suspected of having tree hay fever. Grass pollens are air-borne from about May 30 to mid-July. Many grass pollens cause trouble at this time of the year. The most important are timothy and orchard grass. Plantain is a weed whose pollen will begin to produce symptoms about the middle of May and continue on usually through early June. Plantain pollen may persist through the entire month of June and produce symptoms along with the grasses. However, in most instances, patients whose symptoms do not begin until June are probably hypersensitive to the grasses alone. The most important season is the ragweed era, which usually begins sometime in the latter part of August, depending

*Read May 15, 1956, Section on Allergy, Annual Meeting of The Medical Society of New Jersey.

upon climatic conditions, and continues through September. A few pollen grains may inhabit the air even into the fall.

Relation of Symptoms to Pollen Counts: During the ragweed season, the patient's symptoms will vary with a rise and fall in the pollen count.[2] A study of clinical results in 70 patients during the 1955 season revealed that although this is true for many individuals, it is not always the case. Daily symptoms reported by each patient in this group were noted and assigned a numerical value according to the degree of severity. When these numerical values were averaged daily and plotted against daily pollen counts, the two curves were quite dissimilar. At the beginning, the curves paralleled each other. At the height of the season, the curve representing the "symptom-index" failed to follow the pattern of the "pollen curve." It remained high and inelastic throughout the remainder of the season in contrast to the sharp precipitous rises and falls of the more elastic "pollen curve." This marked dissimilarity would seem to indicate that there are other factors affecting the "symptom index" which make it generally independent of the radical variations in the concentration of atmospheric pollen. Many of the factors that may be responsible for the persistence of symptoms during this period, and even following the disappearance of pollen from the air, have already been previously indicated. However, as yet, there is insufficient proof that such causal relationship exists.

ASSIGNED NUMERICAL VALUE FOR SYMPTOM INDEX

1. No hay fever or slight hay fever.
2. Up to 4 hours of discomfort.
3. Up to 8 hours of discomfort.
4. Unable to work for 2 hours.
5. Unable to work for 4 hours.
6. Unable to work for 6 hours.
7. Unable to work for 8 hours.
8. Asthmatic reaction.

Molds: Mold sensitivity is important during the hot, humid summer months. Symptoms recurring particularly during the period between the end of the grass season and the beginning of the ragweed season should suggest the possibility of allergic coryza caused by molds. Mold spores are abundant in the outside air, and are found widely distributed *indoors*, particularly in damp cellars and in the dust of homes. Schaffer and Seidmon[3] made an excellent study of the mold content of air in northern New Jersey. They were able to culture 51 fungi over a twenty month period. They found the peak of incidence curve in June and July, and stressed the importance of fungi in the inhalant seasonal allergy. Of all mold spores in the New Jersey area, the Alternaria and Hormodendron are the most significant. If at any time during the pollen or post pollen season a patient manifests an exacerbation of nasal symptoms, or if, in spite of adequate pollen therapy, the results have been poor, the possibility of mold sensitivity should be investigated.

Infection and Bacterial Sensitivity: Infection and bacterial sensitivity are major complications of ragweed hay fever.[4] This may also be the major factor in determining the pattern of the "symptom-index" curve. Kern[4] calls attention to the fact that the bacterial allergy in these patients is "strain-specific" rather than "species-specific." He points out that the sensitivity may be of two types: the usual delayed inflammatory tuberculin type reaction, and the rarely occurring acute whealing type of response. When symptoms persist beyond the usual ragweed pollen season, infection may still be a factor, particularly in children, because of increased contact at school.

Foods: The role of food sensitivity in the production of hay fever-like symptoms, must also not be overlooked. Pollen sensitivity may be complicated and coryzal symptoms aggravated by an allergy to seasonal fruits and vegetables.

Insects: Sensitization to the caddis fly in June and July and hypersensitivity to the May fly have been described as causing hay-fever-like symptoms. Particles from insect debris blown about by a strong autumn wind and by winds of hurricane force are possibilities. This hypothesis still needs to be tested.

Dust: In sensitive individuals, dust can become an important factor during the pollen season. It could act as an irritative and also as an allergenic agent. A swollen, sensitive mu-

cous membrane may react to the irritation of small amounts of dust particles in the air. It is important to consider this dust factor at resorts, in the home after returning from a prolonged vacation and at school during and after the pollen season. In the fall, when the home is beginning to be heated and the windows are kept closed, the increased concentration of dust filling the air is an important consideration in the prolongation of hay fever symptoms long after all pollen has disappeared from the air.

Plant Debris: Rebhun, Feinberg and Malkiel,[5] after investigating the antigenic relationship of the three tissues of the giant ragweed plant, state that plant debris may serve as a natural source of allergy to the pollen-sensitive patient. This also requires further investigation.

Miscellaneous Factors: Other factors such as contact with chemical odors and fumes, sudden changes of temperature, and excessive fatigue must be evaluated in each patient. Patients sensitive to ragweed are often found sensitive to pyrethrum as well. Pyrethrum is a common ingredient of insecticidal mixtures used both in the home and in the garden as spray.

SKIN TESTING

ALTHOUGH a well taken and thorough history is probably the most important *single* procedure in our search to clues for diagnosis, we still must seek evidence by other means to confirm our initial suspicions. In this respect the correct interpretation of well performed skin testing is our most useful weapon. Results of skin testing are only confirmatory. They do not supplant a good history and thorough physical examination in each patient.

It is a wise procedure to test each new patient *completely*; that is, to test to all the common allergenic substances, both inhalants and foods, at least once. Skin tests must be correlated with history before accepting them. For reliable results, extracts must be fresh, potent and non-irritating. The scratch test, the puncture test or the intradermal test may be used. The scratch and puncture tests are safer than the intradermal tests. The latter have certain important advantages, however, that make them the procedure of choice by most allergists. For example, the amount of solution introduced may be readily controlled and with less trauma to the skin. The same solutions used for testing may also be used for treatment. The resulting reactions are more accurate, and the degree of sensitivity of each patient more readily gauged, permitting us to classify pollen sensitive cases into degrees of sensitivity designated as "A", "B", "C" and "D". The "A" cases represent the most sensitive type and the "D" cases the least sensitive. This rough classification is a guide in judging the initial dose of pollen extract, the maximum dose that will probably be tolerated and the size of the dosage increments. For classification and treatment, pollen extracts standardized in protein nitrogen units are considered best. The disadvantage of the intradermal technic is the higher rate of constitutional reactions. However, if the principles of sound testing procedures are followed and sufficient care is maintained, the incidence of systemic reactions should be minimized.

TREATMENT

Specific Therapy: In the management of patients with seasonal coryza, specific therapy based upon accurate diagnosis is still the best means for getting good results on a long term basis. Choice of specific antigens, to be used in the hyposensitization program, depends on correlation between reactions to skin tests and the time of occurrence of clinical symptoms. There is no justification for treatment of a patient merely on the basis of a positive skin reaction, even though it be a marked reaction. Occasionally a patient who gives a history of recurrent seasonal symptoms, has no positive skin reaction. Such a patient must be carefully evaluated. Allergens, other than pollens, may be responsible. A conjunctival test may perhaps be of value, particularly in older patients with non-reactive skins. Many patients with seasonal symptoms will give positive reactions

to non-seasonal allergens as well as to the pollens. It is often difficult to evaluate the importance of these positive reacting allergens in contributing to the symptomatology. However, the difference between a good and a bad result will often depend upon such an accurate evaluation and upon specific treatment where indicated. This is especially true in those patients in whom the symptoms continue into the post-seasonal period.

A VARIETY of technics in specific hyposensitization have been advocated. The most effective procedure is the well established routine of starting with small doses in accordance with the patient's tolerance, and slowly increasing the dosage at weekly intervals until maximum tolerance has been reached. These dosages will vary in accordance with the sensitiveness of each patient as roughly estimated by the reactions obtained. There are two schools of thought regarding the total amount of extract that patients should receive. Most allergists favor a higher dosage schedule.[6] A smaller group favor the lower dosages. I agree with the former. The maximum dosage reached at the onset of the season may be continued throughout the season. There are some, however, who prefer to lower the dosage at this time.

It is also important that specific therapy be administered without too much discomfort and with absolute safety. This brings up the question of local and constitutional reactions. Patients should always wait for at least twenty minutes (and in some cases even longer) following treatment before leaving the office. Any severe local or constitutional reactions will usually occur within that time, although they may occur even after a longer interval. A marked local reaction is a warning. The dose of the subsequent injection should then be repeated or lowered one increment.

When changing to new pollen extracts each year, the dosage should be reduced by either one-third or one-half and then gradually increased again. Aside from the danger involved, failure to heed these warnings may result in constitutional reactions that may seriously interfere with the hyposensitization program and lead to poor results. In a study of 56 constitutional reactions occurring in 30 individuals, Tenbrinck[7] stated that such reactions occurred only in pollenosis cases. Peaks of incidence were in March, June and September, at which times the respective seasonal pollen incidence is at its highest. The following reasons were given for these reactions: failure to reduce dosage when changing to new pollen extracts; failure to retest to determine the degree of skin sensitivity before using new extracts; failure to keep dosage at the level reached at the onset of the pollen season; failure to question patients about reactions to previous injections and to the state of their general health.

Finally, in specific therapy, as in the practice of medicine generally, there is no substitute for sound judgment.

Non-Specific Therapy: While we are attempting to prevent the occurrence of symptoms by long-term specific therapy, we must not overlook the necessity of giving immediate relief from suffering and discomfort. During the past few years a large variety of drugs have been introduced for the non-specific treatment of hay fever. Not one of these, not even the steroid hormones, has ever achieved a cure. Nor has it ever been proved that they affect in any way the basic immunologic mechanisms involved.

Antihistamines: The value of antihistaminic drugs as an adjunct in the treatment of allergic conditions is a well established fact. In the treatment of hay fever, a large variety of these drugs have been employed orally, intranasally and parenterally. They have a favorable influence upon such symptoms as sneezing and rhinorrhea, but their effect upon the congestive nasal obstruction in the later stages of hay fever is slight. Given parenterally, either as a concurrent injection,[8] or as a mixture with aqueous pollen extracts,[9] they permit higher maximum dosages with increased safety, and diminish the incidence of local and constitutional reactions. Used in this form they may also produce a more effective clinical relief, particularly in difficult, very sensitive cases that have previously responded poorly to specific therapy alone. These drugs are only pal-

liative. They should never be trusted in severe systemic reactions following injections.

Steroid Hormones: Although the steroid hormones are effective in the symptomatic relief of asthma, they have little place in the treatment of hay fever. These hormones may be used in patients suffering from severe symptoms during the height of the season either because of the failure of hyposensitization and antihistamines, or because no treatment was given prior to the onset of the season. They have no curative value and should be used for the relief of very severe symptoms only. Even here not all cases have been benefitted and significant side effects have been reported.[10]

Nasal Medications: Some nasal medications have incorporated antibiotic, antihistaminic and vasoconstricting agents,[11] and others have used hydrocortisone preparations.[12,13,14] When properly used and not in excessive amounts, they are regarded by their advocates to be of definite value in the relief of distressing symptoms. No systemic side effects and minimal local side effects are reported. I avoid nasal medication as much as possible, particularly in the aged, who are subject to side effects such as tremors, nervousness, tachycardia and palpitation from the use of vasoconstrictors.[15] Rhinorrhea, sneezing and itching are better controlled by the use of oral antihistamines such as chloroprophenpyridamin† and tripelenamine.† If clogging becomes annoying, mild vasoconstricting agents such as phenyl ephrine† 0.25 per cent in the form of drops, or 0.5 per cent as a spray, or ephedrine sulphate 2 per cent by spray are effective. When dealing with superimposed infection, the indicated antibiotics are more effective when used either orally or by injection. The possibility of sensitization must always be kept in mind.

Result of Therapy: Generally speaking, results were satisfactory in about 75 per cent of the patients. In about 20 per cent, results can only be considered as fair. The latter, although deriving some benefit from specific hyposensitization treatment, usually require a great deal of adjunct therapy to get them through the season with a modest degree of comfort. Then there is a difficult group, of about 5 per cent of our patients, who respond poorly or not at all to our standard therapeutic measures. In the latter two groups, and particularly in the last group, greater consideration will have to be given to the possibility of extra-pollen sensitizations; to those factors already known, and to factors yet to be discovered. Improvement in our results will also have to await completion of important work being conducted in the basic sciences. The exact chemical nature of pollen antigens will have to be determined and their relationship to biologic activity studied. Wodehouse,[16] in recent gel diffusion studies of short ragweed extract, showed that there are at least eight antigens present. Other workers have used different methods, such as chemical fractionization, electrophoresis and chromatography to determine antigenic fractions present in a variety of other pollen antigens. Studies[17] involving special technics such as the "coated tanned red cell test" and the "red cell linked antigen test," and serologic studies[18] for complement fixation and inhibition are also being conducted to develop new methods for the detection of serum antibodies to pollen in hay fever patients. Such studies may give us more precise and objective means of confirming clinical diagnoses and of evaluating clinical results with greater accuracy.

†Chloroprophenpyridamin is available as Chlor-trimeton®, a Schering product. Tripelenamine is available under the Ciba tradename of Pyribenzamine®. Winthrop-Stearns market a brand of phenyl ephrine under the tradename of Neo-Synephrine®.

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Bibliography will appear in author's reprints.

Ellis L. Smith, M.D.

Belleville

The Changing Picture in Infectious Diseases*

Role of the Contagious Disease Hospital

If you become discouraged at the apparently slow progress we seem to make month-by-month in medicine, step back and take a look at a few decades. As Dr. Smith here points out, the improvement over such a time period becomes excitingly obvious. In his own field of communicable diseases, Dr. Smith raises the very serious question of the need for the special communicable disease hospital.

The picture in infectious diseases is markedly improved. Hospitalization is now necessary only occasionally. The communicable disease hospital is going out of business. This has been a gradual process over the past twenty years.

What are the changes? What was the picture twenty years ago as compared to the present?

In 1936, streptococcal infections accounted for about two-thirds of the cases treated in our communicable disease hospital in Belleville, New Jersey. At the top of the list was scarlet fever, (1,752); then erysipelas (139); streptococcic sore throat (31); and impetigo contagiosa (29). Acute laryngitis, pharyngitis and cellulitis accounted for 159 cases.

Mortality rate in scarlet fever was low, being only 0.5 per cent. However, many were very sick with severe toxemia and complications that occasionally led to permanent handicaps. Purulent otitis media occurred in 6 per cent of the cases.

Mortality rate in erysipelas was 7 per cent. The best available treatment was blood transfusions. The infant who recovered usually required ten to fifteen transfusions. Infants under three months of age seldom recovered regardless of transfusions. Treatment for the other streptococcal infections was not specific.

Bacterial meningitides resulted in a very high mortality rate, ranging from 18 per cent in the meningococcal type to 41 per cent when all types were considered together. Although we considered anti-meningococcic serum as a "semi-specific," it cannot be compared with present treatment methods.

In this same year, 1936, we admitted 55 cases of gonorrheal vaginitis. There was no specific treatment. We now rarely see such cases.

What are the changes with respect to virus infections? In 1935, we had 10 deaths in 1,002 cases of rubeola. Of these, 79 had acute purulent otitis media and 55 broncho-pneumonia. Empyema followed many of the pneumonias. In 1935, some 135 myringotomies and 39 mastoidectomies were performed on scarlet fever and measles cases. We had no specific method to control secondary bacterial infections.

*Read at the Annual Meeting of The Medical Society of New Jersey, May 16, 1956, before Section on Pediatrics, Atlantic City.

At that time it was the aim of health authorities to control communicable diseases by isolation and quarantine. For the most part, this failed.

What is the picture today?

IN 1954 we treated 142 cases of scarlet fever without a death. It was a rarity to see a toxic or septic case. There were only 8 cases of erysipelas admitted and the remaining cases of the streptococcal group were likewise fewer and less severe.

Of 42 cases of meningitis of all types, including 15 meningococcal and 11 influenzal, there was one death. During the last few years there have been no myringotomies and only one mastoidectomy and that was not a communicable disease case.

What are the factors responsible for this change? The most important is the specific action of the antibiotics and the sulfa drugs both therapeutically and as a prophylaxis in many instances. The latter is very helpful in the prevention of complicating bacterial infections in virus diseases.

Another factor is immunization against diphtheria, whooping cough and tetanus. Many of you younger doctors will be surprised to know that as late as 1929, we treated 1,164 cases of diphtheria at our hospital. Today, we rarely see a case. Better understanding, improved hygienic living and the securing of a physician more promptly has helped a great deal.

For several years, leaders in the hospital field have advocated that each general hospital have an isolation unit; thus a communicable disease hospital would not be needed. I think this is a sound idea. It could be accomplished by following the rules of medical asepsis. We physicians should set a better example in following these rules.

In actual practice in most situations, the general hospital is administered by lay officials without much advice from the physician. With respect to a given patient, there may be social and economic as well as a medical problem. But as a matter of expediency the medical problem is allowed to dominate, while in truth it may be relatively unimportant.

520 Belleville Avenue

Average State Society Dues: $42

With annual dues of $30, The Medical Society of New Jersey is found at the modest end of the roster, when state medical societies are listed by dues. In the October *Medical Economics*, a list shows that state medical society dues range from $20 (Alabama) to $100 a year (Nevada). The average is $42. In the eleven southern states, the total single dues aggregate $355 which averages $32 a year. In the rest of the country (which includes New Jersey), the 38 societies* aggregate $1703 in single dues which works out at $44.50 a year. Thus, in our part of the country, average dues are $44.50 a year, while the figure for New Jersey is only $30. States having higher dues than $30 are: Kentucky, Massachusetts, Mississippi, Nebraska, Vermont and Washington where dues are $35; Florida, Idaho, Illinois, Kansas, Minnesota, Michigan, New Hampshire, North Carolina, Oklahoma, Oregon and Pennsylvania ($40); California, Colorado, D. C., Delaware, Louisiana, Montana, Rhode Island, Texas and Utah, where the figure is $50; in the four states of Arizona, Iowa, Maine and Wisconsin, the doctor pays $60 a year to his state society; the toll is $70 or $75 in New Mexico, North Dakota and South Dakota; and $100 in Nevada. At the other end of the scale, three states (South Carolina, Ohio and Alabama) levy only $20 a year, and nine of them charge $25, which was the New Jersey figure until recently. The nine states with a $25 a year dues are Arkansas, Connecticut, Georgia, Montana, New York, Tennessee, West Virginia and Wyoming.

*There are 49 societies, not 48, since the Medical Society of the District of Columbia corresponds to a State Society.

Sam C. Atkinson, M.D.

Cedric C. Carpenter, M.D.

Summit

Seborrheic Dermatitis

Evaluation of Therapy*

When hundreds of remedies are recommended, none is probably sovereign. This is the case with seborrheic dermatitis. Doctors Atkinson and Carpenter, however, do list in tabular fashion, the preparations which have had the best success score in their hands.

It would be difficult to find a modern home with a medicine cabinet roomy enough to contain all the external and internal remedies that have been suggested for seborrheic dermatitis. The reason for this unusually larg stockpile of medications is the complexity of seborrheic dermatitis. Individual variations and complications preclude the possibility of any simple therapeutic approach.

Thus György[1] reviewed the dietary management of seborrheic dermatitis. Excess fats, carbohydrates, alcohol and salt were reduced in an aid to management. Vitamin B complex and liver extract injections were found to be useful in therapy. Varga[2] considered Vitamin A to be an important factor in therapy. Thelin[3] analyzed the role of biotin in seborrheic dermatitis. His favorable conclusion has not been confirmed by other investigators. Wright and Samitz[4] considered Vitamin B_6 (pyridoxine) to be useful in therapy. Gross[5] discussed all the Vitamin B complex factors with particular emphasis on the effects of liver extract when other measures had failed. Andrews, Post and Domonkos[6] favored the use of Vitamin B_{12} as an adjunct to other therapeutic approaches.

Local infection plays an important role in seborrheic dermatitis. The pityrosporum ovale organism has been prominently mentioned but precise pathogenicity has not been proved. Staphylococci are probably the most frequent complicating bacteria. Folliculitis, furunculosis, impetigo and cellulitis are signals for intensive antibiotic therapy. We have used ointments (especially Neomycin®) and the systemic drugs. Colloidal sulfur, according to Combes,[7] is a favorite form of local therapy. Resorcinol® alone or in combination with sulfur is quite efficient. Ammoniated mercury is

*Read before the Section on Dermatology, The Medical Society of New Jersey, Annual Meeting, May 16, 1956.

1. György, P.: Arch. Derm. & Syph. 43:230 (Feb.) 1941.

2. Varga, A.: Arch. Derm. & Syph. 183:15 (1942).

3. Thelin, F.: Rev. Med. Suisse. 69:347 (May) 1949.

4. Wright, C. S., Samitz, M. H. and Brown, H.: Arch. Derm. & Syph. 47:651 (May) 1943.

5. Gross, P.: Arch. Derm & Syph. 43:504 (March) 1941.

6. Andrews, G. C., Post, C. F. and Domonkos, A. M.: New York State Journal of Medicine, 50:50 (Aug. 1950).

7. Combes, F. C.: New York State Journal of Medicine, 46:401 (Feb.) 1946.

more effective than most of the other old and new remedies but it has a higher incidence of sensitization. It should be avoided in the acute phases in favor of a conservative approach, preferably compresses. Hydroxyquinoline† (3 per cent) cream and powder have been extremely valuable. As a rule hydroxyquinoline† in any form is mild and not likely to sensitize.

Selenium sulfide,‡ as a shampoo, has been the most effective medication for uncomplicated seborrheic dermatitis of the scalp. We have also used it in other areas such as the axillae and groin when complications were not apparent. Selenium sulfide‡ has the undesirable warning label of toxicity but we have seen no ill effects from the shampoo or the jelly.

Duemling[8] analyzed the effects of sodium sulfacetamide lotion.§ In our experience it has been useful and well tolerated in the superficially infected and inflamed areas of seborrheic dermatitis. Sulfacetamide§ is indicated when other medications, especially mercury, were poorly tolerated. There is a low incidence of sensitization and it is a welcome addition to our therapeutic collection. Recently Fanburg[9] reported favorably on sodium sulfacetamide§ in the treatment of seborrheic dermatitis. Interestingly enough, his "cure" rate (within 5 or 6 weeks) was similar to ours.

Emotional disturbances such as anxiety and stress play a part in seborrheic dermatitis.[10] Sedative and tranquilizing drugs have an important place in the management of this aspect of the disease.

Review of personal experiences covers a period of 15 years and includes 264 patients. This is a small incidence of seborrheic cases but represents patients followed, until discharge by one of us, as improved. All of these patients presented several areas of involvement other than the scalp.

†Commercially available as Vioform®-Ciba.
‡Commercially available as Selsun®-Abbott.
§Commercially available as Sebizon®-Schering.

8. Duemling, W. W.: Arch. Derm. & Syph. 69:75 (Jan.) 1954.

9. Fanburg, S. J.: Journal of The Medical Society of New Jersey, 53:78 (Feb.) 1956.

10. Wittkower, E. and MacKenna, R. M. B.: British Journal Dermat. 59:281 (Aug.) 1947.

Various forms of therapy are illustrated by charts:

Chart I: This displays the 4 treatment catogories.
Chart II: External therapy.
Chart III: Internal therapy.
Chart IV: Office procedures.

CHART 1. EVALUATION OF THERAPY IN 264 PATIENTS FOLLOWED UNTIL IMPROVED

Type of Therapy	Number of Weeks Under Therapy
1. Antiseptics other than antibiotics—1943-1950	5.2
2. Antihistaminics—1948-1951	5.0
3. Antibiotics—1948-1953	5.7
4. Newer antiseptics and steroid ointments	5.2

CHART 2. EXTERNAL THERAPY — SINGLY OR COMBINATION

(in decreasing order of value)

1. Neomycin®
2. Mercurials
3. Sulfur
4. Tars
5. Silver nitrate
6. Cortisone ointments
7. Salicylic acid
8. Cleansing sol (acid type)
9. Selenium sulfide
10. Resorcin®
11. Hydroxyquinoline
12. Antihistaminics
13. Scalp "tonics"
14. Antibiotics (other than Neomycin®)
15. Tincture of Green soap
16. Iethyol
17. Sulfacetamide
18. Estrogen (creams, lotions)

CHART 3. INTERNAL TREATMENTS

(in decreasing order of value)

1. Diets
2. Antihistaminics
3. Antibiotics
4. Vitamins
5. Arsenicals
6. Liver extract
7. Thyroid extract
8. Vaccines
9. Sarsaparilla extract‡

‡ A sarsaparilla extract is available under the Bischoff tradename of Sas-Par®.

CHART 4. TREATMENT OF SEBORRHEA IN OFFICE

	Per Cent
X-radiation	41
Ultraviolet therapy	25
Silver nitrate and ultraviolet therapy	13
Grenz radiation (eyelids, groin and scalp)	2
Goeckerman treatment	1

We have analyzed the various combinations of therapy that have been of sufficient value in patients with seborrheic dermatitis to eventually discharge them as improved. These individuals ranged in age from infancy to 89 years but most were in their late thirties and early forties. For the most part, eruptions had been present about 3 weeks before patients came for help. In some instances an adequate result was achieved in a week but in others as much as 6 months was necessary. Average time for all categories was a little over 5 weeks. In this group, there were 11 recurrences that necessitated further therapy; the others lapsed from observation and presumably stayed well. No formal "follow-up" was carried out.

Unfortunately, controls were not possible. These were all private patients and were treated with the best combination of available medications. Newer approaches were tried as they appeared. Comparable results with old and new drugs suggest that there is no single treatment of choice and the results vary with the individual. Resistant cases responded to x-radiation, Grenz radiation and ultraviolet light regardless of the local therapy involved. Internal medications such as arsenic (sodium arsenite or Fowler's solution), antibiotics, vitamins (multiple and B complex), liver extract injections, antihistaminics, and more recently tranquilizing drugs (Rauwolfia compounds, chlorpromazine, Miltown®) all played a part in controlling certain phases of the disease.

129 Summit Avenue

"Enjoy Walking—Hate Standing"

Fainting can be prevented by contracting and relaxing the lower leg muscles, especially the calf muscles, if one is required to stand for a long period of time. So says Rivlin* in a discussion of the problem of soldiers fainting on parade.

"The calf muscles act as a voluntary peripheral heart, surging the venous blood onwards and upwards by means of a complicated system of non-return valves at the junctions of the superficial with the deep veins," Dr. Rivlin explained.

That is why patients with varicose veins and ulcerated legs enjoy walking but hate standing still, he added. In fact, varicose veins predispose the standee to fainting.

Not only does the motionless erect posture encourage venous pooling in the limbs with a diminution of venous return, but this occurs in a circulation whose net volume has been concurrently decreased by fluid loss into the tissues of the lower limbs.

*Rivlin, S.: Fainting on Parade, The Practitioner, 176:541 (May) 1956

Rauwolfia-Ephedrine as a Hypotensive-Tranquilizer*

The authors report on 69 patients treated with rauwolfia preparations, 20 of whom developed untoward side effects. Among these were nasal congestion, excessive drowsiness, overeating, alarming nightmares, irrational behavior, and an incapacitating degree of agitated depression.

In all cases it was found possible to continue the use of rauwolfia preparations by adding ephedrine. A dosage recommended is 8 mg. of ephedrine with 0.1 to 0.25 mg. of reserpine, the combination being given three times daily —in the early morning, near noon and at 4 p.m. The ephedrine in this dosage did not interfere with the hypotensive action of the reserpine, and did relieve the side effects. In each case, treatment with the ephedrine-rauwolfia alkaloid combinations gave complete relief and a continued favorable therapeutic response. The authors point out that the blood-pressure-lowering effect of the rauwolfia alkaloid is in no way impaired by its combination with ephedrine.

*Feinblatt, T. M., Feinblatt, H. M., Ferguson, E. A., Jr.: J.A.M.A. 161:424 (June, 1956)

Obituaries • • •

DR. LEOPOLDO GAMBACORTA

The senior member of Newark's medical family of Gambacortas died on August 23, 1956, with the passing that day of Dr. Leopoldo Gambacorta. Born in Italy in 1880, he was graduated in 1905 from the medical school of the University of Naples. In 1922, after building a successful practice in his native land, he came to Boston where he practiced to 1939. From that year until this summer he did general practice in Newark. Dr. Gambacorta was affiliated with the Columbus Hospital in Newark. He was the son of one physician and the father of two others.

DR. LEE E. GRISCOM

One of New Jersey's oldest in-harness practitioners, Dr. Lee E. Griscom, finally has lost the fight with death, his old enemy. On August 17, 1956 Lee Griscom died at the age of 84. Born in rural Salem County during the presidency of Ulysses S. Grant, Lee Griscom was graduated from Philadelphia Hahnemann in 1895. He moved to Camden and for more than half a century had been identified with civic and professional affairs in that county. He joined the staff of the West Jersey Hospital and gradually rose from general assistant in 1896 to chief of pediatrics in 1927. Like many good old-fashioned practitioners, Dr. Griscom was a skilled surgeon as well as a competent internist.

Dr. Griscom helped found the Rotary Club in Camden. After retiring from active hospital service he became a member of, later chairman of the Board of Trustees of his hospital. He was also active in the Philadelphia Pediatric Society.

DR. LEROY G. KIRKMAN

Born in Port Jervis in 1875, Leroy Kirkman was graduated from Princeton in 1896. He then entered the medical school of Columbia University and was graduated in 1900. After interning at the old Newark City Hospital he entered private practice in Newark in 1902. For more than a half a century he ministered to the medical needs of the Newark community. He was interested in all branches of medicine and was identified with Babies Hospital, with the Hospital and Home for Crippled Children, with the Newark City Hospital and with St. Michael's Hospital. In 1930 he was elected president of the medical staff at the Hospital and Home for Crippled Children. In 1943 he retired from active practice at the age of 79, and was given a citation by the staff at St. Michael's Hospital. Dr. Kirkman died on August 3, 1956.

DR. GEORGE L. ORTON

One of Union County's senior physicians died on August 11, 1956 with the passing on that day of Dr. George L. Orton. A native of Vermont, he was graduated in 1909 from the Jefferson Medical College of Philadelphia. While a medical student he became interested in boys' welfare work, and was instrumental in establishing Camp Kilkare at St. Albans in 1906. He died while returning from the 50th anniversary of that camp. After completing his internship, he came to Rahway as surgeon to the Reformatory, and remained in that position until 1934. Dr. Orton was one of the select group of physicians and civic leaders who founded the Rahway Hospital. He became attending surgeon there. Dr. Orton was also president of the Union County Medical Society in 1928. Dr. Orton was a co-founder of the Rahway Rotary Club. He was 78 years old at the time of his death.

DR. WILLIAM PEDRICK

Born in 1896, Dr. William Pedrick died on August 10, 1956. He had been graduated from the Temple University Medical School in 1922, and after interning in Wilmington, Delaware, he crossed the river a year later to establish an office in Glassboro, New Jersey. There he became a prominent community figure. For a quarter of a century he headed the Gloucester County Health Association. He was chief plant surgeon at the Owens-Illinois Glass Company's Glassboro plant. For almost two decades he was senior physician to the Glassboro school system. He was a church vestryman, a past-president of the local Board of Health and active in the Industrial Medical Association of North America. He was also active in the work of the Gloucester County Medical Society.

Announcements • • •

Unusual Tumor Seminar

A slide seminar on "Unusual Tumors" will be held on Saturday, December 8, at Essex House, Clinton Avenue and Broad Streets, Newark, beginning at 2 p.m. This is sponsored by the New Jersey Society of Clinical Pathologists and the State Department of Health. Moderator will be Dr. Arthur Purdy Stout, of the Institute for Cancer Research, College of Physicians and Surgeons of New York.

Microscopic slides and histories of the cases to be presented have been mailed to the society members. The diagnoses submitted will be discussed by Dr. Stout.

This Seminar has annually attracted most of the pathologists of New Jersey and surrounding states as well as other physicians interested in the field of tumor diagnosis. All are welcome.

A social hour and dinner, with Dr. Stout as guest, will be held at the Essex House after the seminar. Dr. Shulman is chairman of the seminar and will receive reservations for the dinner. Write to Dr. Murray Shulman, 913 South 20 St., Newark 8, N.J. for reservations and information.

Course in Air Pollution

An intensive, two-week course on "Air Pollution" for physicians will be given by the New York University Post-Graduate Medical School from November 26 through December 7, 1956.

The course will review the basic toxicology of the principal air pollutants, meteorologic factors, the effects of air pollution on agriculture and commerce, and methods for sampling and analyzing the toxic components. Methods of control and the pattern of governmental regulations will be studied. Tuition is $75.00.

For further information: The Dean, Graduate Medical School, 550 First Avenue, New York 16, New York.

Approved Courses in Philadelphia

The courses below listed are approved by the Academy of General Practice. They are given at the Albert Einstein Medical Center in Philadelphia. For details, write to Department of Medical Education, Albert Einstein Medical Center, 500 Reed Street, Philadelphia.

Subject	Days	Hours	Starts (1956)
Allergy	Thursdays	2 p.m. to 5 p.m.	Oct. 18
Rheumatology	Wednesdays	2 p.m. to 5 p.m.	Oct. 17
Endocrinology	Wednesdays	2 p.m. to 5 p.m.	Oct. 24
Electrocardiography	Wednesdays	2 p.m. to 5 p.m.	Nov. 7
General Practice Advances	Wednesdays	10 a.m. to 12 p.m.	Nov. 7

Diabetes Symposium

The New Jersey Diabetes Association and the State Department of Health jointly sponsor an afternoon symposium on diabetes to be held at the Academy of Medicine in Newark from 2 to 5 p.m. on Wednesday, October 17. Papers will be presented on carbohydrate metabolism in pregnant women, on the sulfonylureas in diabetes, and on the management of diabetes in pregnancy.

Course in Blood Bank Technics

A refresher course in blood banking technics and related subjects will be given at Rutgers on November 3, 1956. Arrangements are being made by the Division of Laboratories, New Jersey State Department of Health. The course is co-sponsored by the Blood Bank Commission of The Medical Society of New Jersey.

Blood bank director and technicians in charge of blood banks are invited to attend. For registration forms, write to: Director of Laboratories, State House, Trenton, New Jersey.

Blood Bank Symposium

The Blood Bank Commission has arranged a seminar for Friday, November 2, at the Presbyterian Hospital in Newark. The Hospital is at Ninth Street and Tenth Avenue. The day will be given over to a full and free discussion of blood bank policies.

For further details write to Sylvan E. Moolten, M.D., Middlesex General Hospital, New Brunswick, N. J.

Beling Memorial Lecture

For the tenth time, the physicians of New Jersey will participate in a C. C. Beling Memorial Lecture. This one will be on Wednesday evening, November 14 at the VA Hospital in East Orange. The lecture starts at 9 p.m. Subject: "Homeostasis in Nervous and Mental Disease." Essayist is Warren McCullough, M.D., physiology scientist at Massachusetts Institute of Technology.

All doctors who wish to, are invited to meet the speaker at an informal dinner party at Zig's restaurant, 589 Central Avenue, Newark, at 6 p.m. For dinner reservation, write to Dr. Ira Ross, 179 Irvington Ave., South Orange, N. J.

Geriatric Symposium

A two-day symposium on "Geriatric Medicine in Daily Practice" will be held at the Waldorf Astoria in New York City on November 19 and 20. There will be morning sessions starting at 9 a.m. and afternoon sessions starting at 2 p.m. The colloquium will terminate at 5 p.m. each day. There is no fee. The moderators constitute a roster of distinguished specialists. Detailed program may be obtained from Dr. Edward Henderson of 236 Midland Avenue, Montclair, N. J.

Fellowships in Neuromuscular Disease

The Sister Kenny Foundation provides 5-year scholarships, at stipends of $5000, $6000 and $7000 a year (depending on the worker's qualifications) for research in neuromuscular disease. For details, write to Dr. E. J. Huenekens, 2400 Foshay Tower, Minneapolis 2, Minnesota.

Graduate Courses at Seton Hall

Graduate courses for practitioners are now available through the Seton Hall College of Medicine and Dentistry. A list of courses is tabulated below. For more details write to Graduate Medical Education Director, Seton Hall College of Medicine, Medical Center, Jersey City 4, N. J.

Subject	Time	Place	Starts 1956	Tuition
Obstetrics	Wed. 4:00 p.m.	Newark	Nov. 21	$ 25
Internal Medicine	Thu. 4:00 p.m.	J. C.	Nov. 1	$ 35
Surgery	Tue. 4:00 p.m.	Newark	Nov. 20	$ 35
Surgical Technic	Fri. 4:30 p.m.	Newark	Nov. 9	$200
Biochemistry	Wed. 4:00 p.m.	Newark	Nov. 7	$ 50
Cardiology	Fri. 4:00 p.m.	Newark	Nov. 9	$ 50
Gynecology	Thu. 4:00 p.m.	Montclair	Nov. 1	$ 50
Roentgenology	Tue. 4:00 p.m.	Newark	Nov. 13	$ 50
Radiologic Physics	Tues. 4:00 p.m.	Newark	Feb. 5*	$ 50
Radiation Therapy	Tues. 4:00 p.m.	Newark	Apr. 2*	$ 50
Endocrinology	Mon. 4:00 p.m.	Newark	Nov. 12	$ 25
Reg. Anesthesia	Mon. 4:00 p.m.	Newark	Feb. 18*	$ 50
Vasc. Surgery	Sat. 9:00 a.m.	Newark	Feb. 23*	$200
Surg. Pathology	Wed. 3:30 p.m.	S. O.	Nov. 7	$150
Gyn. Pathology	Wed. 3:30 p.m.	J. C.	Feb. 27*	$ 50
Dermatology	Fri. 4:00 p.m.	Newark	Feb. 8*	$ 50

J. C. indicates course given at Seton Hall College of Medicine in Jersey City.
S. O. indicates course at Seton Hall campus in South Orange.
* Indicates 1957 date.

County Society Reports . . .

Bergen

The first regular meeting of the fiscal year 1956-57 was called to order by President William T. Knight in the auditorium of Bergen Pines County Hospital, Paramus on September 11 with 66 members present.

Dr. Knight announced that the annual fall public forums co-sponsored by this Society and the Bergen Evening Record will be held October 18 and 25. The first of these will be on "Overweight and Underweight" and the second on "Early Detection of Cancer."

The meeting was addressed by Dr. Theodore B. Van Itallie of the Harvard Medical School on "Treatment of Diabetes Mellitus by Oral Preparations." His talk was exceedingly timely, of great interest and ably presented.

CHARLES P. CAMPBELL, M.D.
Reporter

Middlesex

The annual meeting of the *Middlesex County Medical Society* was held on June 20 at Metuchen at 6:30 p.m. After a sumptuous steak dinner the meeting was called to order at 8:25 p.m. by the president, Dr. Joseph Sandella. Dr. Reitman presented the speaker of the evening: Dr. Ralph E. Lapp, Director of Nuclear Science Service—whose topic "The World of Tomorrow" was not only a most timely but extremely interesting subject. The speaker took the members on a historical tour of the development, accomplishments and future of atomic research. He discussed the future in terms of the peace time applications of nuclear energy which have been demonstrated to some extent already. Nuclear energy as a source of power has already been accomplished, as a source of electricity and now in the making and ultimately as a source of readily available power for transportation. The discussion which followed was lively and widespread.

The panel of candidates as presented by the Nominating Committee was accepted. Elected and installed to office for 1956-1957 were:

President—Sidney D. Becker, M.D.; Vice-President—Gerard R. Gessner, M.D.; Secretary—Reuben Levenson, M.D.; Treasurer—George J. Kohut, M.D.; Reporter—Morton M. Klein, M.D.

Judicial Medical Ethics Committee — B. F. Slobodien, M.D., Chairman; E. J. Brezinski, M.D.; M. M. Dunham, M.D. (For one year). F. M. Hoffman, M.D.; W. E. Sherman, M.D. (For two years).

Board of Trustees for 1956-1957 — Joseph F. Sandella, M.D., Chairman; Charles H. Calvin, M.D., Malcolm M. Dunham, M.D.; Howard Dieker, M.D.; S. David Miller, M.D.; W. Edgar Sherman, M.D.; Marshall Smith, M.D.; John Albert Smith, M.D.; Henry T. Weiner, M.D.

The meeting was concluded by the relinquishing of the Chair to the newly elected president, Dr. Sidney D. Becker, who spoke of the future plans of the Society.

ALFRED J. BARBANO, M.D.
Reporter

The Worst Auto Toll in World History

Yes, 1955 was a banner year. It won the blue ribbon for the nation's worst automobile accident toll in history. Traffic deaths totaled 37,800 last year compared with 35,500 in 1954. The injury count reached 2,158,000 compared with 1,960,000 in the previous year.

These figures are taken from *Fatal Fallacies*, a booklet published by The Travelers Insurance Companies.

Excessive speed was the most dangerous driving mistake again in 1955, killing 12,700. The 1954 total was 12,380 persons. The injury total resulting from excessive speed was 702,560, compared with 659,000 in 1954.

The pedestrian record was the only bright spot in the 1955 accident picture. It reflected improvement for the fifth consecutive year. Pedestrian casualties were reduced to 230,400, compared with 235,060 in 1954.

Drivers under 25 years of age were involved in 28 per cent of 1955's fatal accidents, although they comprise only 14 per cent of the total of all the nation's drivers.

Weekend crashes accounted for 15,730 killed and 766,090 injured. The 1954 weekend record was 13,980 killed and 678,000 injured.

Crossing between intersections, "jay walking," and stepping into the street from behind parked cars are the chief causes of pedestrian deaths and injuries.

Book Reviews • • •

The Menninger Story. By Walker Winslow. Pp. 350. New York 1956. Doubleday. ($5.00)

Achievement might have been greater for Dr. Charles Frederick Menninger of Topeka, "C. F." as he was known, in the atmosphere of a great teaching center. Maybe not. Relative isolation in the mid-western city could have been a challenge, the force that drove him on in his obsessive desire for better medicine in his area, the sharing of knowledge and experience with his colleagues. At least, it was not a deterrent.

Returning from Rochester, Minnesota, in 1908, C. F. expressed to Flo and their three sons a resolve to establish a clinic patterned after Mayo's. To a degree accorded but few, he saw his dreams come to fruition. Edwin, unfortunately, had to forego a medical career, but Doctors Karl and Bill went on to join their father. The Menninger Clinic became a reality.

Most interesting are the author's character sketches and the family design, from which the Clinic in its present form is a natural sequela. Basically alike, yet different, the one member of the household was the complement of the others. It was a happy home. The more enduring things in life were stressed, the motif of love flowed throughout, there none was a stranger. It was a deeply religious home. It was in losing their lives, C.F. in the field of medicine, Flo in the field of religion, that both found life.

Cradled in such an atmosphere, the course of Karl and Bill was pre-determined. It is not by accident that values eternal have been the guiding force in their lives and the theme of their writings. Able, well-trained physicians, who than they, with their background, could better sense the relationship between the psyche and the soma!

There are many elements to this book. It is a success story in the best American tradition. In it there is romance, drama, medical lore of historical interest, a picture of medicine at the turn of the century, a picture of the revolution in psychiatry. It is a story that should be of interest, and an inspiration, to both the medical and the lay reader.

JOSEPH G. SUTTON, M.D.

Personal Health Record. By Carl A. Dragstedt, M. D. Harrisburg, Penna. 1956. Military Service Publishing Company. Pp. 64. Paper. ($1.00)

Doctors who have had Army or Navy experience know how helpful it was to have immunization registers, health records and other data giving compact information about a patient's health. Now it is possible for the civilian to have this kind of record. The *Personal Health Record* is a pocket-sized, sturdily bound booklet which has spaces for family medical history, childhood diseases, injuries, occupational exposure, record of treatments, special allergies, dental data, operations and hospital stays, and space for writing in the name of preferred physicians, dentists and hospitals. There is a guide to weight and height and also some compact information on poisons and antidotes. There is space for health insurance data. There is also an "emergency data" page for the kinds of things you'd want the intern to know if you were ever littered into a hospital unconscious: Rh, tetanus toxoid record, blood type, blood pressure, diabetes potential, language spoken, hospital insurance number and so on. It is a pity the publisher didn't put this form on the inside front cover. Most people won't carry the whole book. Maybe in the next edition they will reprint this page on a wallet card.

Perhaps this will be just a passing fad. Or maybe it won't catch on at all. But it would be helpful to doctors and hospitals if every one had such a health log. It will save time and tedium in preparing new medical histories at every admission or office visit. It will give an assist to anyone filling social security, insurance or medical forms. If I were an obstetrician I'd give one to every new baby in my practice. We are very meticulous in maintaining business records. We ought to be equally fussy about the record of the most important aspect of our lives: our personal health.

HARVEY BLUESTONE, M.D.

New and Nonofficial Remedies, 1956. By the Council on Pharmacy and Chemistry of the American Medical Association. Philadelphia, Lippincott, 1956. Pp. 540. ($3.35)

As regularly and welcome as the flowers in May comes the current edition of New and Nonofficial Remedies. This annual publication of the A.M.A. has been a *vade mecum* of practitioners for many years. It contains descriptions of drugs evaluated since the last issue of NNR and does not duplicate the listings in the *Pharmacopeia* or the *National Formulary*. Emphasis this year has been more on the basic information concerned with the pharmacology of the drugs and less on such trivial matters as packaging and mixtures. The book includes a metric system conversion table and a list of official and regulatory agencies. The drugs are arranged pharmacologically under such heading as analgesics, immunologic agents, sclerosing agents, and the like. With the present spate of new pharmaceuticals, it becomes more and more necessary for the doctor to have a ready reference method of getting the generic name of drugs which are recommended to him first by tradename. NNR, in its index, provides this information swiftly and authoritatively.

HENRY A. DAVIDSON, M.D.

Extrasensory Perception. Edited by G. E. Wolstenholme, M. B. and Elaine Millar. Boston, Little Brown, 1956. Pp. 241. ($6.00)

The Ciba Foundation arranged a conference in London on parapsychology. Two dozen men of various degrees of skepticism and belief participated. Most were sympathetic, but none were uncritical. There were 14 primary papers covering a wide range of subtopics; and each paper was discussed in breezy, informal style. While few voices were raised in support of clairvoyance, most of the participants believed there was strong evidence that some people had telepathic powers. Several of the speakers indicated hostility to the work of Dr. J. B. Rhine of North Carolina.

There is a chapter here on the simulation of telepathy. The dreary rounds of card guessing and the pedestrian obsession with the mathematics of probability were deplored by some of the participants. The psychoanalytic potential of telepathy was discussed by Gillespie. The ESP possibilities of bird navigation and animal behavior generally were reviewed by several speakers.

The symposium raised more questions than it answered. On the one hand, there is the feeling that it is arrogant of us to assume that Nature ends at the ceiling of our sensory range. On the other hand, there is the fact that experiments in telepathy cannot be reliably reproduced. The pros and cons are interestingly debated here. We owe the Ciba Foundation a vote of thanks for arranging this extraordinary symposium.

ULYSSES M. FRANK, M.D.

Hunterdon Medical Center: The Story of One Approach to Rural Medical Care. By Ray E. Trussell, M.D., M.P.H., Cambridge, Mass., Published for The Commonwealth Fund by Harvard University Press, 1956, Pp. 236, Illustrated. ($3.75)

This volume presents a readable and informative account of how a rural New Jersey community established a medical and health center designed to serve its own particular needs. Dr. Trussell, first director of the Hunterdon Medical Center and now Executive Officer of the Columbia University School of Public Health tells the story of the Center from the initial proposal in 1946 through the opening of its doors for community service in July 1953. He covers various aspects of policy formulation, fund raising, hospital design and construction, programming and subsequent staffing, equipping and operating a modern rural medical and health center. Emphasis is given to relationships between general practitioners and specialists, hospital in and out-patient care, multiple screening studies to assay community health needs, mental health activities, parental participation in pediatrics and other ventures of a voluntary hospital in the community health program.

In affiliation with New York University - Bellevue Medical Center, Hunterdon Medical Center developed its own new community program for rural medical care. In his introduction to the book, Dr. C. E. De La Chapelle writes, "In the two years since the opening of its doors, Hunterdon Medical Center has more than fulfilled its reputation as one of the most unusual projects in the chronicles of medical care in this country. It represents a new formula for medical service in a rural community, in which a hospital represents the medium by which patients remain under the care of their family physicians, who in turn have the complete cooperation, as well as guidance when needed, of a full-time specialist staff. In this type of organization the full-time staff supplements the family physicians but does not supplant or compete with them. The environment is that of a university-type medical center in which education and training as well as investigation play such important roles in medical care."

The composition of this book is attractive and its illustrations excellent. Dr. Trussell's account of Hunterdon Medical Center describes a new adventure in American medicine.

FRED B. ROGERS, M.D.

Tribute to Freud. By H. D. (Hilda Doolittle Aldington). New York 1956. Pantheon books. Pp. 180. ($2.50)

While not all psychiatrists are enchanted by Sigmund Freud, the specialty itself has never been the same since Freud finished his work. Whether you believe that Freud was a neurotic mystic, whether you think he enunciated some basic truths which are now old hat, or whether you consider him infallible, you have to recognize that his figure overshadowed western psychiatry during the first half of this century. The library of personal freudian reminisences is growing.

This "tribute to Freud" is another item, a veritable antiphony of praise for the father of psychoanalysis. If you are a disciple, this may well be added to the sacred writings. If you are antifreudian, this book is sheer idolatry. It is a poetically written (Mrs. Aldington is a well known poetess) account of fragments of Mrs. Aldington's personal analysis by Freud. It reflects the standard confusion of father, God and the doctor—the patient's own father was a frustrated doctor. You do not get a very clear picture of the writer's psychoneurosis, nor indeed of her personal life. Presumably she had a husband—she makes casual reference to her daughter—yet the husband gets pretty short shrift. Persumably Mr. Aldington was important in her emotional life, but nowhere does he appear.

The reader gets many pleasant and intimate glimpses of Freud's life. The narrative is a series of disconnected odes rather than a straight story. The foreword, by Merrill Moore, the distinguished New England psychiatrist, says "Never have I seen sentiments so subtly conveyed . . . not even in the writings of Freud himself." To all but Freud devotees, the mood may, indeed, be a bit too subtle. After symbolism passes through the screen of the analyst and then the screen of the poetess, it may become too refined.

HERBERT BOEHM, M.D.

TUBERCULOSIS *Abstracts*

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ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXIX October, 1956 No. 10

TB on Skid Row

By Donald J. Ottenberg, M.D., Bulletin, National Tuberculosis Association, June, 1956.

For many years the blackest spot on the map of tuberculosis morbidity and mortality in Philadelphia has been "skid row." In 1953-54 one of these census tracts had a tuberculosis mortality rate of 469 per 100,000 compared to a rate of 20.1 for the city as a whole. The reported active case rate was 1120.4 compared to 79.8 for the whole city.

Knowledge of such a startling tuberculosis problem stimulated the Philadelphia Tuberculosis and Health Association, with other voluntary agencies, to conduct organized x-ray surveys among skid row inhabitants as far back as 1952. The prevalence of serious tuberculosis was almost unbelievable, but relatively few homeless men would accept an x-ray. The most elaborate promotional schemes, ranging from individual "buttonholing" on the street to offering free Sunday dinners, could not overcome the evasiveness of skid row men.

The hope of reaching a larger number of these men in surroundings more conducive to cooperation led to the plan to x-ray the nightly yield of drunks, vagrants, and peace disturbers held for magistrate's court at a city police station. A proposal to conduct such a survey on a demonstration basis was laid before the chairman of the Committee on Public Health of the City Council, who enthusiastically carried the plan to the Mayor and the Police Department for approval.

Earlier experience with homeless men served to emphasize the importance of a well-organized survey procedure, with prompt and aggressive followup. In previous surveys between the time of the film taking and the time when results became available, a large number of the men had dropped out of sight. An address given by a person one day, if not incorrect to begin with, was likely to be of no value in locating that person a few days later.

A further complication was that one-night hotels do not permit the men to remain in the rooms during the day when public health nurses ordinarily would come to interview them. In the evening, when the men might be "at home," the nurses were not available to seek them out.

Facing such obstacles, the survey team put much effort into pre-survey consultations among staff members from the Police Department, the City Divisions of Tuberculosis Control and Public Health Nursing, the local health districts and the voluntary agencies.

A portable photofluorographic unit of the association was set up at the police station and the men who had been picked up by the police during the night were offered a chest x-ray at the time of discharge after a magistrate's hearing in the morning. With few exceptions, the men who had been in custody took the magistrate's offer more as an order than an invitation. Almost all who were discharged during the period of the survey were x-rayed.

Films were developed on the day of exposure, except on week-ends, and were read the next morning before the regular work day of the city public health nurses. Positive reports were phoned to the health center in the appropriate district, enabling the nurses to visit the address of the person with suspicious findings the same day, which except on week-ends was the day after the film had been taken. Cases read as advanced

active tuberculosis were reported directly to the Division of Tuberculosis Control so that hospital beds could be made available immediately.

Persons not located by the public health nurses during the day were reported at the end of the day to two male investigators who continued the search at night.

In the six-week period 1750 persons were x-rayed. Tuberculosis was read in 151 films, or 8.6 per cent. Among the 151 films read "tuberculosis" were 37 labelled active from the film appearance alone. This diagnosis was confirmed in the clinic in 20 of the 37. Another diagnosis was reported for 6, while no reports were available on the remaining 11. Twelve additional active cases were diagnosed among persons whose survey films had been read "tuberculosis of indeterminate activity," giving 32 proved active cases altogether, a rate of 18 per 1000. Twenty-two of the 32 had not previously been known to the Health Department, and at least half of the 10 previously known were not under supervision at the time of the survey.

It seems likely that there was more active tuberculosis in the group than the rate indicates, since no follow-up diagnoses were available on 30 per cent of those whose films were read "probably active" and 58 per cent of those read "activity indeterminate." The yield of active disease is at least 18 times greater than one would expect in the population at large and is in general agreement with reports from other metropolitan areas.

Although 136 cases read tuberculosis were referred for further study, 63 or 46 per cent failed to appear and 47 of these 63 men could not be located. Within 24 hours they had returned to the anonymity of skid row. Apparently they were devoid of any permanent ties that might help to trace them from one day to the next.

The survey resulted in hospital treatment for 11 men and brought or returned 50 others to clinic supervision. This more than justified the expenditure of money and effort. At the same time the results pointed up the peculiar problems presented by a skid row population and the need for special technics, particularly in follow-up.

Those who have thought of homeless men as vagabonds who use skid row only as a temporary stopping place were surprised to discover that 30 per cent of the men were born in Philadelphia and 78 per cent consider Philadelphia as a place of permanent residence. Of those who listed Philadelphia as their permanent home, 97 per cent had been in the city over six months and three out of four had been there over 10 years.

It is clear that the skid row problem goes beyond the consequences of any one disease, even such a serious disease as tuberculosis. Skid row exists because the men on it are incapable of making an adequate life adjustment. They are properly to be considered among the mentally or emotionally ill. Alcoholism touches most of them, although no categorical answer can be given to the question whether the men are homeless because they drink or drink because they are homeless.

There is no easy solution to the problem, and some authorities believe it is impossible to control tuberculosis on skid row without controlling skid row itself. Some of the new ideas under consideration in Philadelphia are a separate alcoholic's court with an associated center for treatment and rehabilitation, municipal public shelters to replace flop houses, certification of lodging houses, and tuberculosis hostels to supply after-sanatorium lodging for homeless men.

One of the greatest needs is to understand the men on skid row better than we do. It is surprising how little we know about the psychogenesis of skid row personality and the social forces that tend to perpetuate it. The need to study the problem in a systematic way is urgent.

In the meantime, casefinding surveys in police stations, prisons, alcoholic rehabilitation centers and the like will give the richest yield of new significant cases of tuberculosis. While such programs inevitably meet frustrations and neither rid our large cities of skid rows nor skid rows of tuberculosis, they undoubtedly reduce the pool of infected persons and thereby help to control tuberculosis in our cities.

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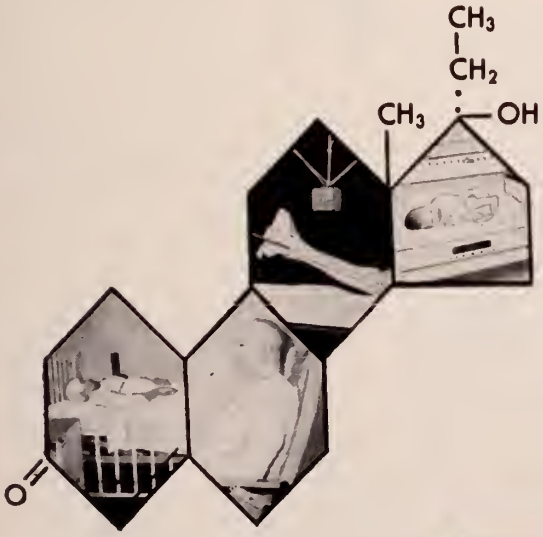
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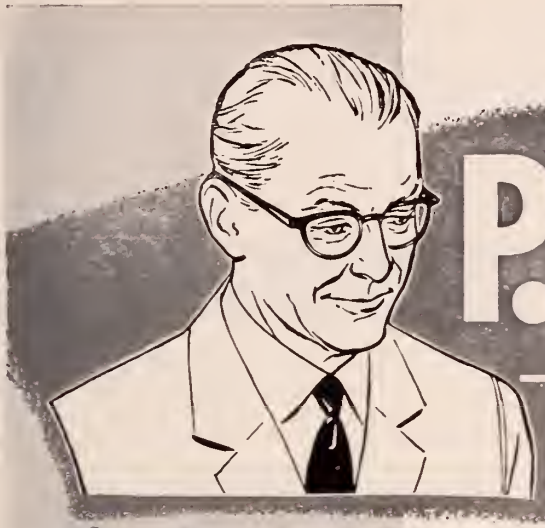
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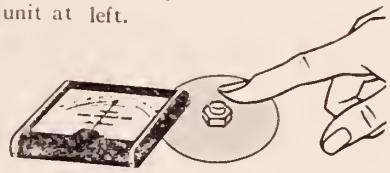


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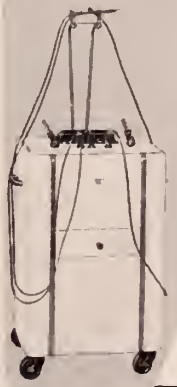
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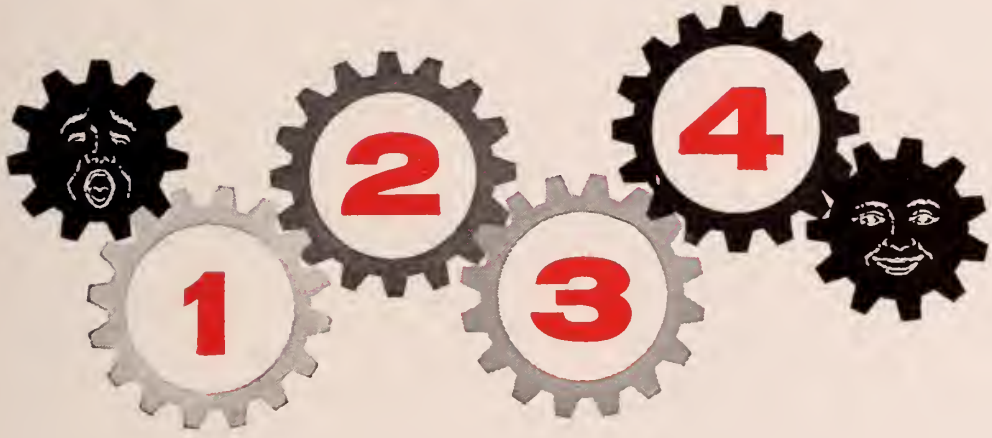
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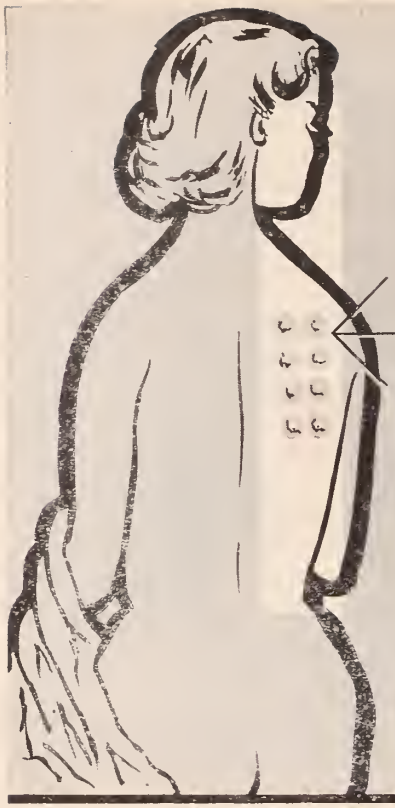
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Mechaneck, I., Annals of Allergy; 12: 164: March 1954
Rosen, F. L., J. Med. Soc. N. J.: 51: 110: March 1954
Mueller, H. L., & Hill, L. W.: N. E. J. of Med: 249: 726. 1953

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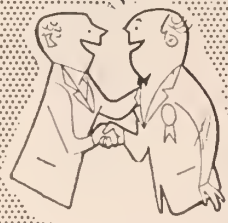
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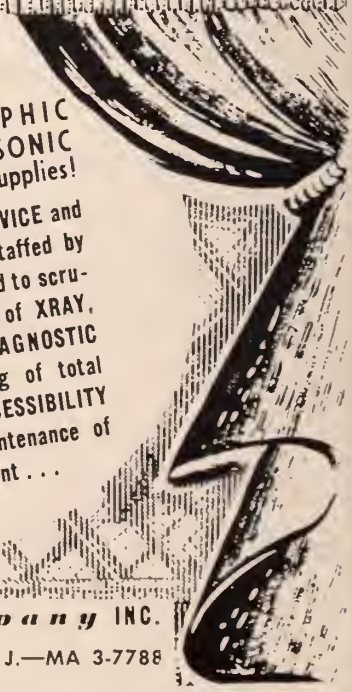
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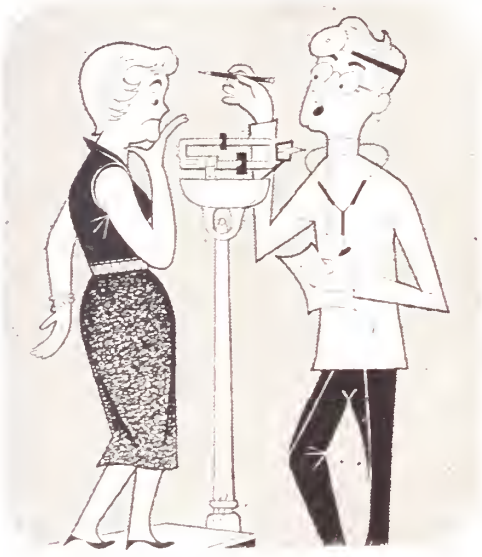
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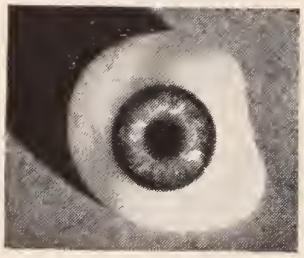
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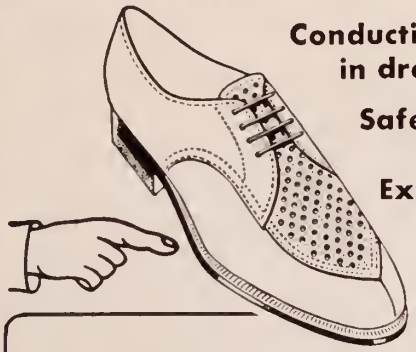
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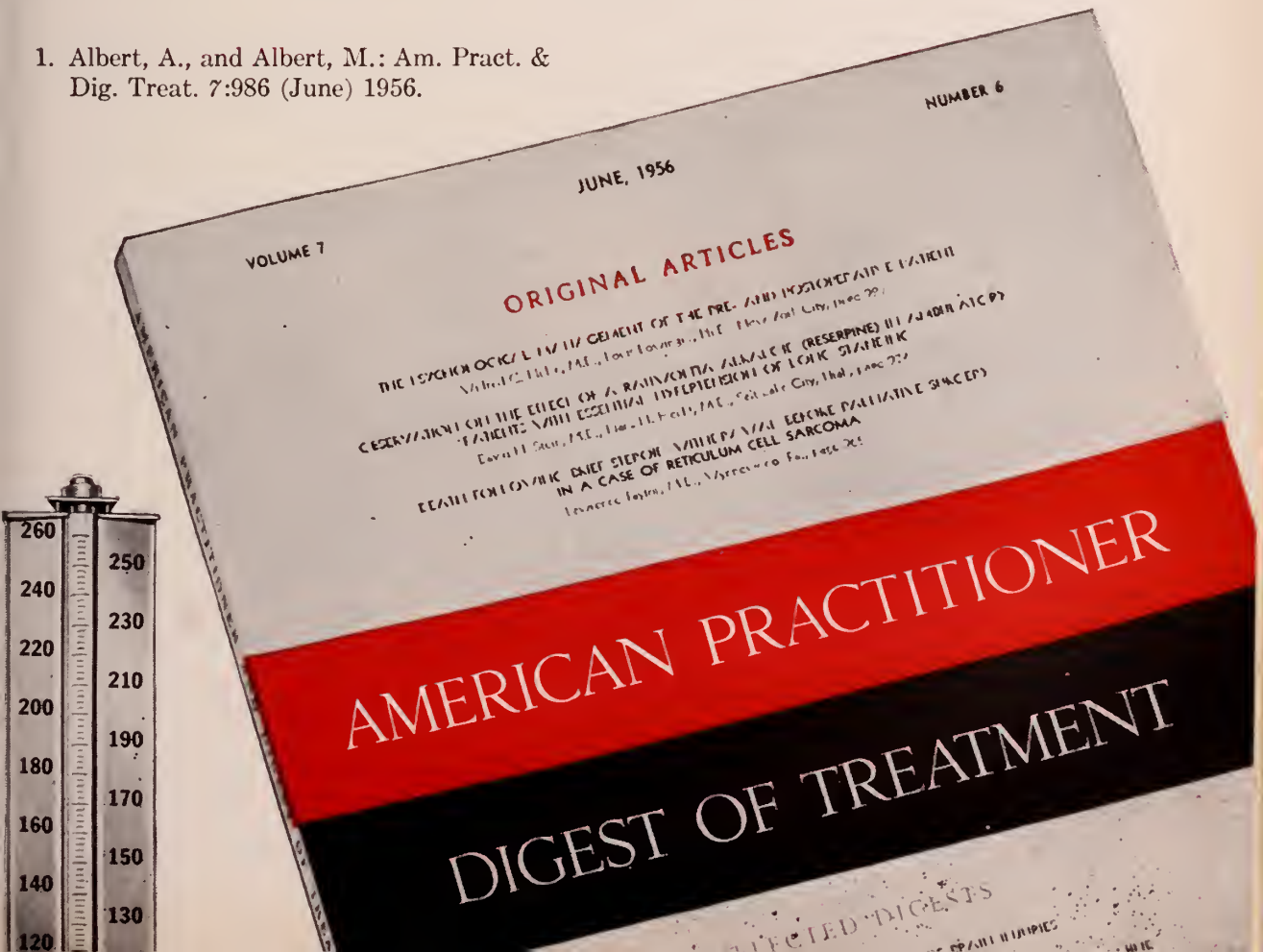
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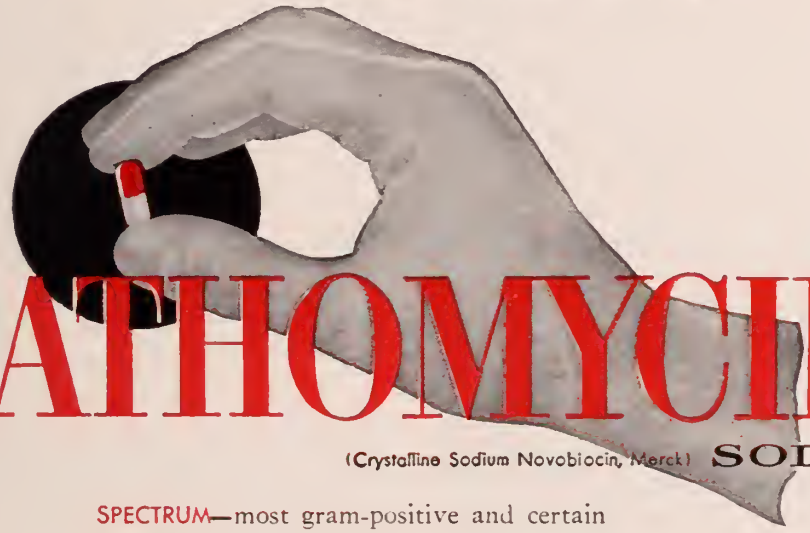
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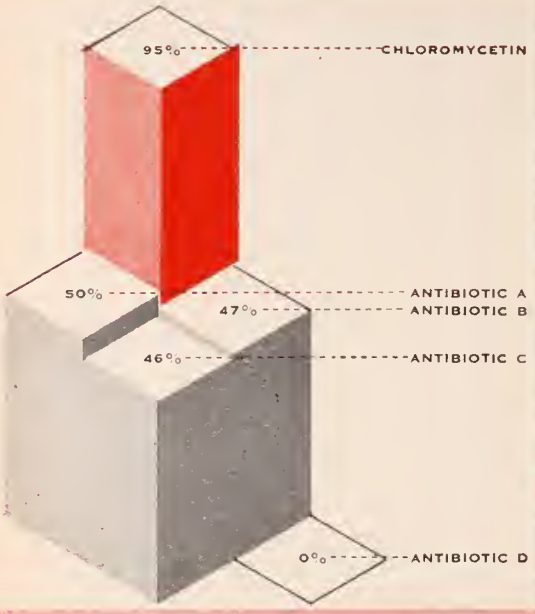
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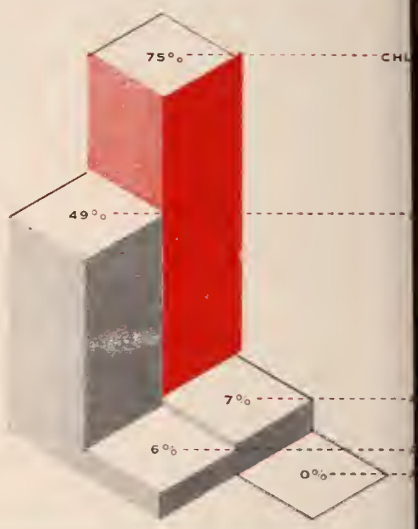
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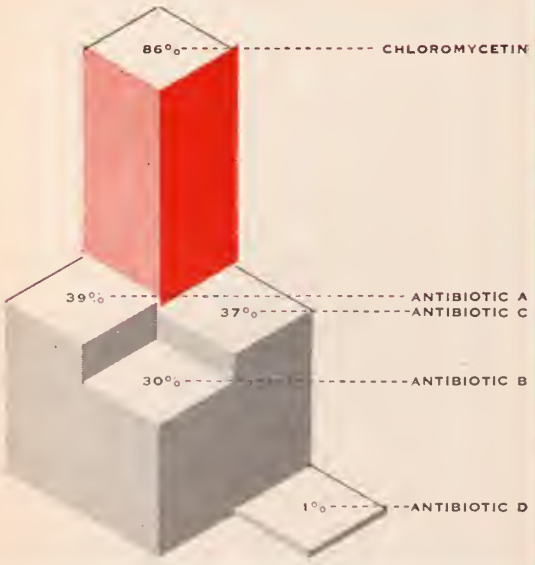


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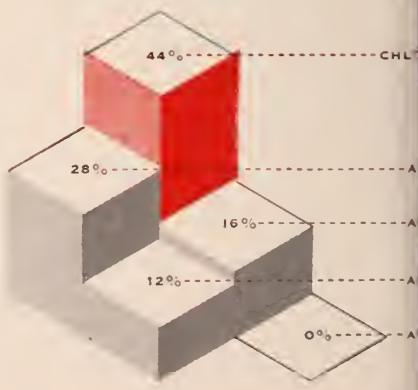


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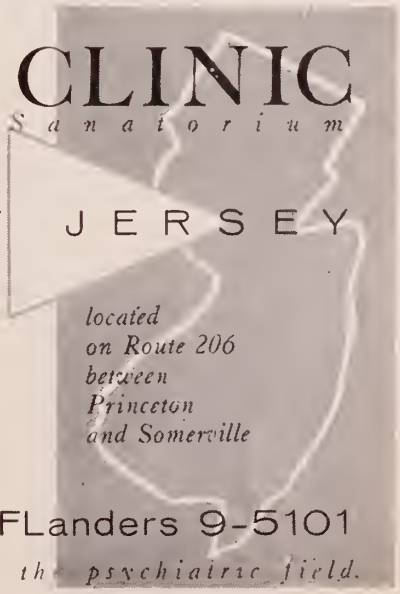
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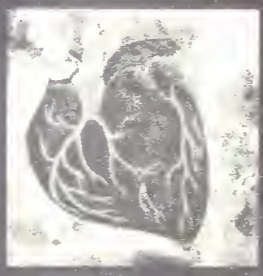
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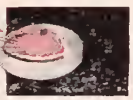
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References: 1. Boland, E. W., *J.A.M.A.* 160:613 (February 25) 1956. 2. Margolis, H. M. *et al.*, *J.A.M.A.* 158:454 (June 11) 1955. 3. Bollet, A. J. *et al.*, *J.A.M.A.* 158:459 (June 11) 1955.

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[1]Posner, A. C., *et al.;* Further Observations on the Use of Tetracycline Hydrochloride in Prophylaxis and Treatment of Obstetric Infections, *Antibiotics Annual* 1954-55, pp. 594-598.

Lederle

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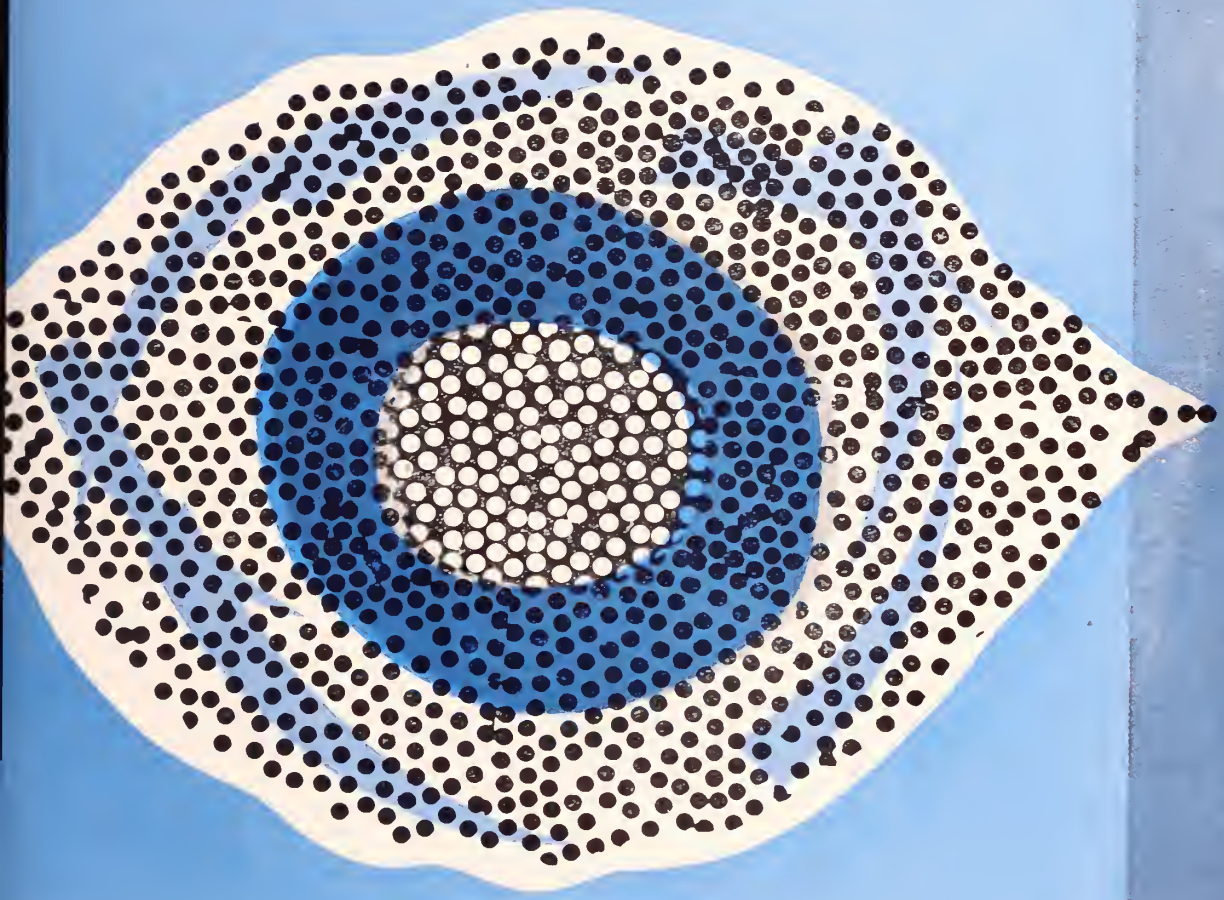
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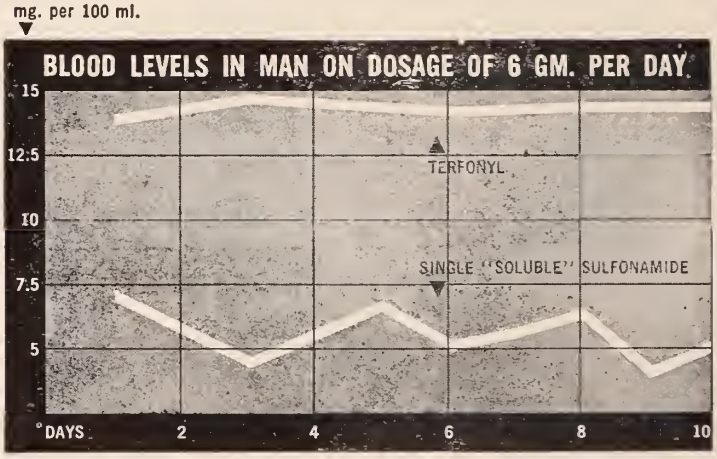
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– After Lehr, D., Modern Med. 23:111 (Jan. 15) 1955.

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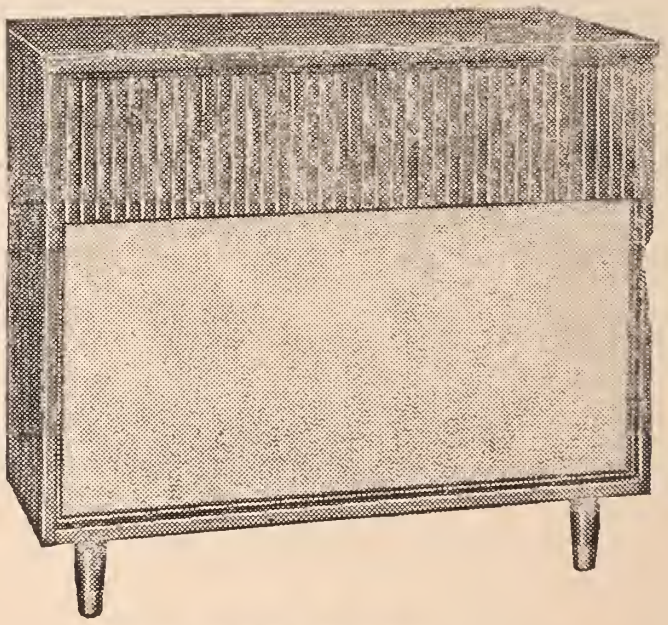
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Benzedrine* Sulfate (racemic amphetamine sulfate, S.K.F.)	2.5 mg.
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1. Medical Gynecology, ed. 2, Philadelphia, 1950 *T.M. Reg. U.S. Pat. Off.

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in antibiotic therapy, particularly for the 90% of patients treated at home and in the office

Superior control of infectious diseases through superior control of the changing microbial population is now available in a new formulation of tetracycline, outstanding broad-spectrum antibiotic, with oleandomycin, Pfizer-discovered new antimicrobial agent which controls resistant strains. The synergistic combination now brings to antibiotic therapy: (1) a new fuller antimicrobial spectrum which includes even "resistant" staphylococci; (2) new superior protection against emergence of new resistant strains; (3) new superior safety and toleration.

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Sigmamycin is a new antibiotic formulation providing: (1) the unsurpassed broad-spectrum activity of tetracycline, the outstanding broad-spectrum antibiotic discovered and identified by Pfizer; (2) the action of oleandomycin, the new antimicrobial agent which combats those strains, particularly among staphylococci, now resistant to tetracycline and other antibiotics.

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Dosage: 1 to 2 capsules q.i.d.

Supplied: Capsules, 250 mg. (oleandomycin 83 mg., tetracycline 167 mg.) Bottles of 16 and 100.

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1. Mathews, Morris and Moyer: Am. Pract. & Dig. Treat. 6:360 (Mar.) 1955.

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relieves pain

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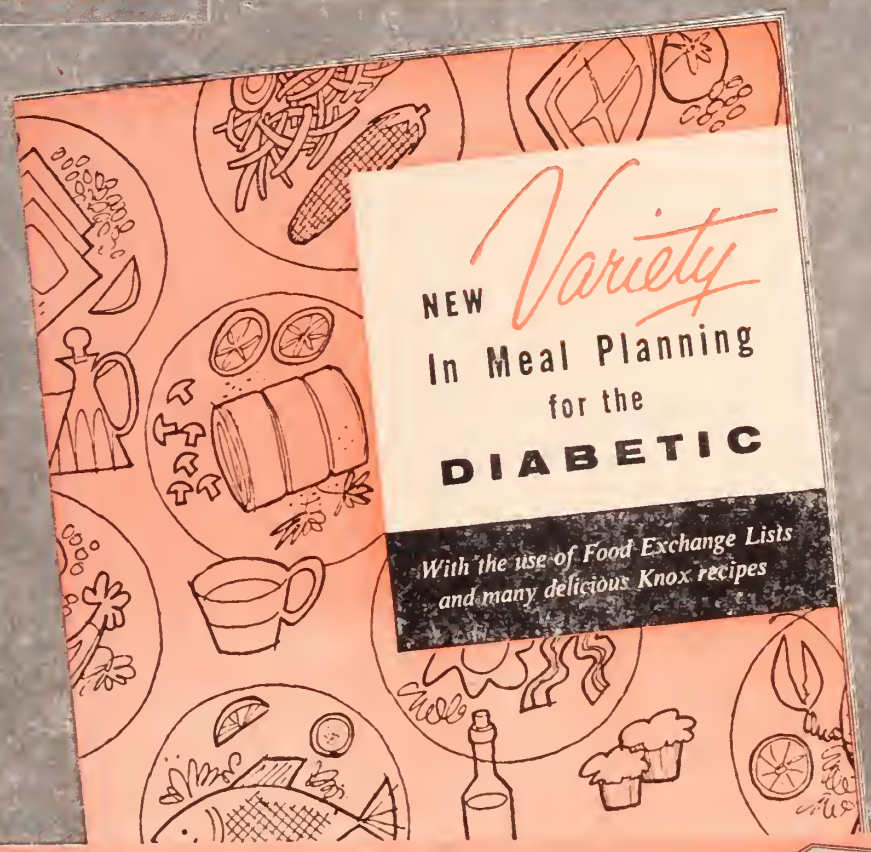
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Newest Knox Brochure Aids Dietary Management of Diabetics



Although more than 50% of diabetics can be managed with proper diet, continued success is dependent upon proper motivation of patients. Determination to abide by dietary restrictions is also important for the diabetic being managed with insulin.

The new Knox booklet "New Variety in Meal Planning" has been prepared to help the physician enlist the patient's enthusiasm for dietary measures and to help maintain this enthusiasm. It explains the importance of diet to the diabetic, shows him how to use the newest dietary advance —Food Exchange Lists[1]—and then describes how to provide tasty variety with 14 pages of tested, diabetic recipes.

"New Variety in Meal Planning" makes no attempt to prescribe a system of treatment. It shows how the recipes described may be used to good advantage in practically any system of diabetic management. If you would like a supply for your practice, use coupon below.

1. Developed by the U. S. Public Health Service assisted by committees of The American Diabetic Association, Inc. and The American Dietetic Association.

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Please send me.....copies of the new Knox diabetic brochure describing the use of Food Exchange Lists.

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KARO® SYRUP . . . meets the need for a highly potent source of infant carbohydrate

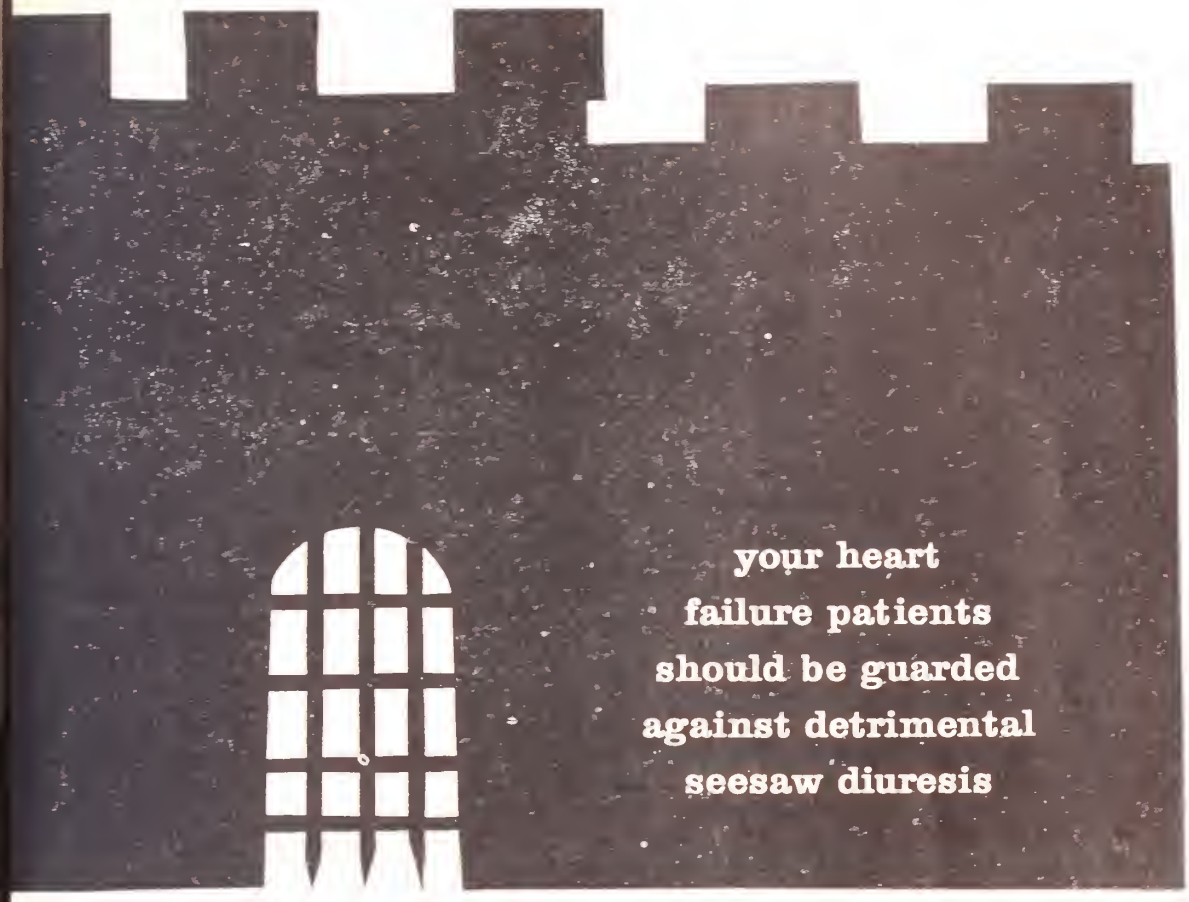
The need for carbohydrate, particularly during the rapid growth period of early infancy, is well recognized. One highly effective means of assuring adequate carbohydrate is by the addition of Karo syrup to the milk formula.

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effective for constipation

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*An important study of chronic constipation at a New York hospital discloses these striking results:**

In a group of 194 chronically ill patients, averaging 71.6 years of age, regular feeding of Dannon Prune Whip Yogurt produced excellent results. Completely normal bowel habits were re-established in 187 patients, or 95.8%. They required no laxatives during the period of administration. Improvement in skin tone, seborrheic dermatitis, intestinal stasis and pruritus ani were also noted.

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Dannon Prune Whip Yogurt is a smooth, custard-like milk food—highly palatable. Made from fresh milk, with about 50% of the butterfat removed, it is low in calories, high in nourishment and has the delicious flavor of old-fashioned prune whip. You may recommend Dannon Prune Whip Yogurt for your most stubborn constipation cases with the same gratifying results described in the above report. Prescribed regimen is to eat one container nightly before bedtime, for three weeks.

*Ferrer, F. P., and Boyd, L. J.: Am. J. Dig. Dis., 22:272, 1955

For literature, write Dannon Milk Products, Inc., 22-11 38th Avenue, Long Island City 1, N. Y.

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New improved formula - now the best tasting. Used like table salt.

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Erythrocin in treating tonsillitis and otitis extern

2/22/56 DISCHARGE SUMMARY

Patient, white male, age 4, entered the clinic on 2/13/56, with a history of yellow discharge from the right ear, a fever, and sore throat of two days duration.

Temperature orally was 100°, pharynx infected, tonsils inflamed, crusted purulent material seen in right ear canal; tympanic membrane normal. Diagnosis -- tonsillitis and otitis externa.

Culture revealed Staphylococcus aureus, coagulase positive, resistant to penicillin and sensitive to erythromycin.

ERYTHROCIN (erythromycin) was started in doses of 25 mgm/kg -- 400 mgm in 4 equally divided doses.

After 24 hours of therapy, patient was afebrile and comfortable. T = 99.6. Throat slightly infected. Secretions in ear canal were dry and both tympanic membranes were normal.

Culture on 2/15 showed no coagulase positive staphylococci or other pathogens. On 2/22, follow-up exam showed him to be completely asymptomatic and free of unusual physical findings. The drug was stopped at this time.

Final Diagnosis: tonsillitis and otitis externa due to Staphylococcus aureus.

Result: complete clinical bacteriologic cure after 9 days with ERYTHROCIN therapy.

*Communication to Abbott Laboratories

"clinical response good or excellent"

In one recent study, 18 patients with acute follicular tonsillitis and septic sore throat, were given erythromycin. Infecting organism was *Str. pyogenes*. The investigator stated, "*In all 18, the clinical response could be regarded as either good or excellent.*"[1]

This, of course, is only one of many reports showing the effectiveness of ERYTHROCIN against coccic infections. You'll get the same good results (nearly 100% in common, bacterial respiratory infections) when your prescription reads *Filmtab* ERYTHROCIN Stearate.

"toxicity lower in erythromycin-treated patients"

After a study of 208 patients treated with erythromycin (78), procaine penicillin (78) and a placebo (52), the investigator stated: ". . . *the incidence of toxicity* (compared to procaine penicillin) *was significantly lower in the erythromycin-treated patients.*"[1]

Actually, ERYTHROCIN stands on a remarkable record of safety. After four years, there's not a single report of a severe or fatal reaction attributable to erythromycin. Also, allergic reactions rarely occur. *Filmtab* ERYTHROCIN Stearate (100 and 250 mg.), is available in bottles of 25 and 100, at all pharmacies.

Abbott

® Filmtab—Film sealed tablets, Abbott; pat. applied for.

1. Herrell, W. E., Erythromycin, Antibiotics Monographs, No. 1, p. 29, New York, Medical Encyclopedia, Inc., 1955.
Idem p. 30.

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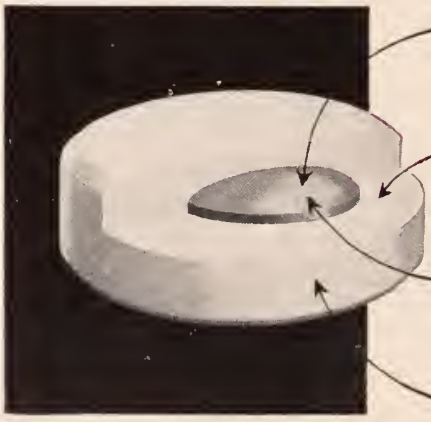
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Physical separation of the steroid component from the aluminum hydroxide as provided by the Multiple Compressed Tablet construction assures full potency and stability of prednisolone.

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SUPPLIED: *TEMPOGEN and TEMPOGEN Forte —in bottles of 100 Multiple Compressed Tablets. (TEMPOGEN Forte provides 2 mg. of prednisolone.)*

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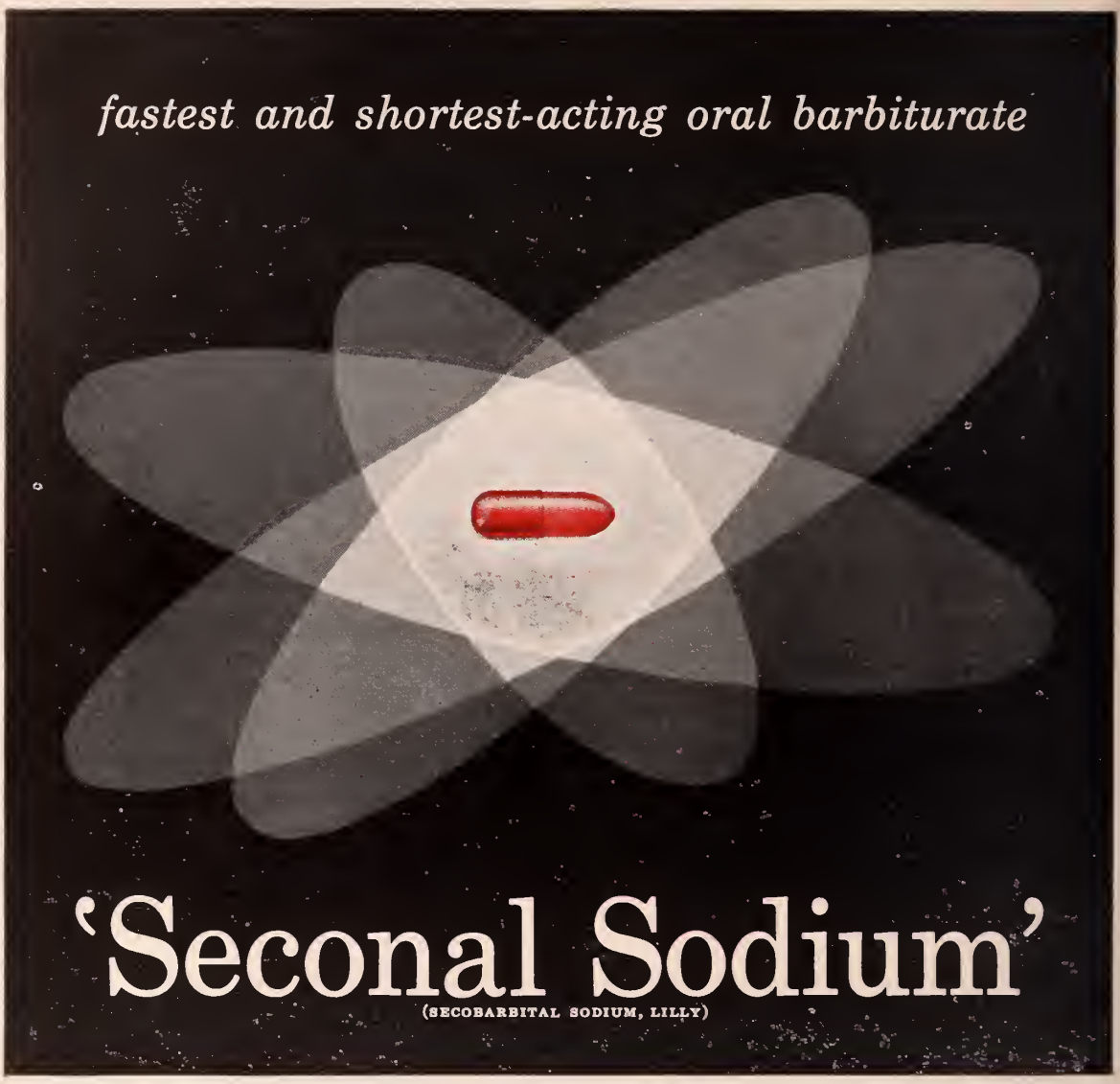
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THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

That's a Headache

Headache is the universal symbol of trouble. To call a job a "headache," or to identify a person as "a headache" is to say a good deal. The head, it is felt, is the seat of thought, the house of that peculiar faculty which makes us somewhat higher than beasts even if somewhat lower than angels. The prime mover of a project is its head man. To go to the head is everywhere (except in the Navy) a way of seeking authoritative information. To go to the head of the class is to earn envy. Even the heart, most potent motor of our lives, is supposed to make itself subordinate to the head. The word "capital" in all its ramifications comes from the word for head. So does the word *chef* as well as "chief" in all its variants.

So the number one complaint in all medicine at all times is headache. In any roster of symptoms, the head heads the list. If this is the aspirin age, the era owes its eponym to the equation of headache and trouble. Much medical thinking has always focussed on "what causes the headache?"

Most headaches are self-limiting, and stop after treatment—or (in time) after no treatment at all. If we start with a theory, and treat the headache according to that theory, we will, more often than not, get good results. So the theory seems to be proved. In 1890 the common cause of headache was bad air; in 1910 it was focal infection. In 1920 it was need for eyeglasses, in 1930 it was sinusitis (remember the oddly named 'vacuum headaches'?) and in 1940 it was stretching of the meninges. By 1950 the prime cause had become "tension" headache.

Friedman [1]—who certainly ought to know—defined "tension headache" as "that which occurs in relation to constant periodic or emotional conflicts." He and his co-workers screened 400 cases of "tension headache" for emotional factors [2] and guess what they found? In 72 per cent of the cases, the subjects "admitted" emotional factors. Note that verb: "admitted" — as if having an emotional factor were a crime to which one confessed. How about the other 28 per cent—the ones where

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the patients would not confess an emotional component? In all of these, the Bronx physicians found unconscious emotional factors. Thus the definition proves itself. You start with tension headache, and, by unremitting search, you find an emotional component in 100 per cent of cases.

An observer might wonder if anywhere there exists a human being with no emotional problem at all. Such a character would surely be a psychiatric case, for—in insisting that he has no emotional problems—he would be grandiose, unrealistic and evasive. To say that patients with "tension headache" have emotional problems is to say that patients with "tension headache" are human.

Not all doctors will agree with this. Not even all Bronx doctors. There is, for instance, Dr. Murray Braaf and his colleague Dr. S. Rosner.[3] They think that "psychogenic" pain in the head is really orthopedic pain in the neck. In fact, after examining 500 presumably "psychogenic" cases of headache, Braaf and Rosner find that "only 8 per cent were in definite need of psychotherapy." So the psychogenic nature of psychogenic headache depends on what part of the Bronx you work in. At Lebanon Hospital, 90 per cent (no less) of the patients had had some previous, usually trivial neck injury and had damaged discs between cervical vertebrae.[3] Eight per cent needed psychotherapy. The other 2 per cent apparently had head-centered headache. That's at Lebanon Hospital, on the Grand Concourse. Cross to Gun Hill Road, however, and, in the same boro, The Montefiore staff believes that 100 per cent of "tension" headaches are psychiatric problems.

The headache is real enough. Since there are no pain nerve endings in the brain, tension headache must be an extra-cortical phenomenon. This does not get us much forwarder, however. The brain is infiltrated with blood vessels, and pain is produced when vessels are stretched. And the fifth nerve, a pain conductor *par excellence*, is pretty close to the brain in spots. The venous sinuses, the scalp and the meninges are all potential pain sources.

Emotions certainly can play a role here. Emotions cause blood vessels to dilate (as seen in the old days when maidens blushed) and emotions can throw muscles into spasm. People that are "tense" in the emotional sense, exhibit muscle "tension" in the physiologic sense. Emotions can pour out epinephrine, push up the blood pressure, whip up the heart rate, and increase the activity of muscles and glands . . . enough to give any one a headache!

"Tension headache" is alleged to be commoner in women. In our culture it is unmanly to have a headache without a gross organic cause, so the doctor's usual reaction to headache in a male is to put it down to an obscure structural change. In a woman, the doctor (at least the man-doctor) is quite willing to ascribe it to emotions. Blumenthal[4] though, says that any kind of emotional conflict, any kind of anxiety can cause headache. Since it is respectable for a man to worry about jobs and finances, men are entitled to worry-produced headaches too.

You'd think that when doctors talk of headache, they'd be agin it. Not all doctors though. Moench,[5] for instance, argues that tension headache is a good thing because it keeps you from retreating into fantasy. It is the price for living in a real world and it is a bargain, if the alternative is psychosis. Just let the top get tensed up and there is no need to blow it. Another observer who favors headache is M. F. Shapiro.[6] He relates headache to rage, hostility and violence, and suggests that "tension headache" is a benign expression of such emotions, a sort of moral equivalent of war. Friedman[7] is willing to accept that theory in disguised form. He argues that the patient, feeling guilty because of these hostile impulses, punishes himself by getting a headache and thus relieves his guilt.

To the doctor, "tension headache" is the

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1. Friedman, A. P.: *Modern Headache Therapy*. St. Louis 1951. Mosby.
2. Friedman, A. P.: *Neurology*, October 1954. *Also* see the January 17, 1953 issue of the Journal of the American Medical Association.
3. Braaf, Murray and Rosner, S.: New York State Journal of Medicine, March 15, 1953.
4. Blumenthal, L. A. *et al.*: American Practitioner, October 1954.
5. Moench, Louis G.: *Headache*. Chicago 1951. Year Book Publishers.
6. Shapiro, Mortimer F.: New York State Journal of Medicine, Aug. 15, 1955.
7. Friedman, A. P.: American Practitioner, October 1954

model psychosomatic disorder. It has emotional implications and it has a physiologic substrate. The patient can be soothed by reassurance, given relief by letting him talk it out, given suggestion by placebos, given tranquility by medication and given attention by finding the doctor understanding, receptive and easy to talk to. That's a big program for a single symptom. But in some respects it is the most challenging symptom in medicine.

Taking the Joy out of Life

We doctors are not ordinarily considered kill-joys. Most of us believe that the simple pleasures of the flesh are good for the flesh, and that cheeriness is good medicine generally. But there are always a few Cassandras among us. A decent respect for mathematics makes us uncomfortable about advising patients to continue smoking if they have peripheral vascular disease, a chronic laryngeal affection, or potential pulmonary pathology. We are divided about beverage alcohol. Some of us see it as a fine prophylaxis for coronary or peripheral vascular disease. Others will not buy stock in the "hair of the dog that bit you" thesis.

We seldom pontificate about the evils of late hours, and when we advise a patient to take a trip to Florida or Monte Carlo, it is often on the urging of the spouse. We have no objection to relaxation, vacations, long sleep, tasty food or other joys of life. While kissing may, indeed, transmit germs, we have embarked on no anti-kissing campaigns. Recently Gibson Craig reported* on the evils of shaving—or, as Dr. Craig puts it, on "shaving as a cause of skin disorders." He points out that improper shaving technic may cause granulomata, papules, ingrown hairs or pustules.

Against such somber warnings as these, it is pleasant to see that a recent forum (reported in Lakeside Laboratories' Dec. 1955 *Diuretic Review*) announces that beer is helpful to cardiacs. It has, says the writer of this arbeit, two virtues: low salt, effective diuresis. Even the bureaucrats of Britain's National Health Act recognize this. While they do not consider mouth washes or sulfur soap to be medicines, they do recognize the medicinal value of ale, beer, sherry wine and stout.

The doctor's primary job is to prolong life (hardly to prevent death: no man can do that). But perhaps his secondary job is to make that life as comfortable as possible.

**Ciba Symposia* 7:195, December 1955.

T. I. D.

"A teaspoonful three times a day" is the theme song of much medical practice. Perhaps the original idea was to mix the medication with the food. Or perhaps the hope was that, since you had a *habit* of eating three times a day, maybe you could build a *habit* of taking the necessary medicine.

Rationalizations—sheer rationalizations. The real reason is a magic. There is magic about "three." One, two, three and away we go. The three witches and the thrice three witches. Good things, or bad ones, come in threes. The fates, the muses, and many other minor gods, come in threes or in three-three combinations. And the Queen of Wonderland was not the only one who thought that what you say three times must be true.

Three times a day, three times a day, the mystic number must have healing powers. To be sure, modern man has outpaced the ancient three. Today's sophisticate eats breakfast, luncheon, dinner *and* supper: four, not three meals a day. And this does not even count the coffee break and the cocktail hour. But the

habit persists, and a large proportion of prescription *signa** (where they carry anything more specific than "as directed") read "after each meal" or "three times a day." Unfortunately drug action is not always so neatly packaged, so a new fashion has been introduced. This is to measure the dose by its effect (blood levels, or perhaps the development of untoward reactions). It's easy enough in a hospital, where the intern may be told to adjust the dose according to the blood count, but it is a bit harder in outside practice. A generation ago, they used to treat chorea by giving Fowler's solution until the eyes got puffy. And some dermatologists have been burned because they instructed patients to leave the ointment on until it burned. Such evils flow from our abandonment of the ancient magic. The keepers of the mystic three are not so easily spurned.

Women Really do Live Longer

In almost every community, there are more widows than widowers. And the gap is getting wider. According to Dr. Moriyama's figures (National Office of Vital Statistics) the difference in life expectancy was 3 years during the 1930s; in 1940 the figure was 4½ years; in 1950 women survived men by 5½ years. Now the difference is 6 years. Of course, all life expectancies are slowly moving upward; but longevity among women is moving up faster. It looks as if women are benefitting more than men from the advances in medical science. Or maybe they are more sensible in exploiting those advances. Diabetes and cancer of the breast and genitalia cause more deaths among women than among men. But for all other causes, the death rate is higher among men.

Accidents, murder, suicide, tuberculosis, cancer of the lung, cancer of the gastro-intestinal tract, and, above all, arteriosclerotic heart disease, account for the fact that males lose this grim sweepstakes. Among infants, the death rate (per 1000 population under one year of age) is 37 for boy babies and 28 for baby girls. According to the National Safety Council, there is now one accidental death every six minutes—automobiles and industrial accidents together accounting for half of these. Although home is a dangerous place, with an accident every 7 seconds somewhere in some home—few home accidents are fatal.

The sex difference in death rates is not built-in biologically, but seems to be due to cultural differences. In our country, men do more hazardous work in industry and transportation than women do. Similarly with exposure to weather. Also, women are more sensible about diet and clothes than men. If the present trend continues, there will soon be 140 over-age-65-women for every 100 men in that age bracket. Under present employment practices, this will condemn to unemployment an increasing proportion of our senior citizens and considerably swell the already overpopulated ranks of widowhood. It will affect our insurance structure —probably making it more expensive for men to get life insurance, but (if this is any consolation) cheaper to buy annuities.

One way of reducing the gap would be to increase the death rate among women. A better way would be to bring the male death rate in line with the female rate. If you know of any life insurance company willing to invest funds in a project that will, in the long run, cut its losses, you might suggest this. Do a little research—statistical, clinical, epidemiologic—to find out what habits, practices, or restraints women have that makes them live longer. Women really do live longer. It doesn't as so many widows complain, just seem that way.

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*For the benfit of our younger readers, your greying editor explains that the *signa* of a prescription is the instruction to the patient to be placed on the label. In the older days, the doctor, not the pharmaceutical manufacturer made that decision.

STUART ZEH HAWKES, M.D.

JAMES D. ALLAN, M.D.

Newark

Massive Upper Gastro-Intestinal Hemorrhage*

A Rational Approach to Treatment

Hemorrhage from the upper gastro-intestinal tract is a common and serious medico-surgical problem. Esophageal varices are the prime source of fatal bleeding, but peptic ulcers are the commonest cause of nonfatal hemorrhage. Dr. Hawkes, Attending Surgeon at Newark Presbyterian Hospital and Dr. Allan, Senior Surgical Resident at Martland Medical Center here develop a feasible formula for the management of these cases.

THE past ten years have seen vital revisions in the method of handling upper massive gastro-intestinal bleeding. Only fairly recently a patient with such a problem, no matter what the etiology, was treated expectantly with a minimum of blood and by medical management. Surgery was the occasional choice. Many patients died of exsanguination.

With the advent of blood banks, a shift toward surgery became possible. This trend gained momentum and swung heavily to the side of surgical intervention, especially where the diagnosis of peptic ulcer had been made. Surgery within the first few hours of admission, following the administration of large amounts of blood, became the method of choice in many hospitals.

Purpose of this paper is to define massive bleeding, to analyze some of the pitfalls in this trend, to discuss current management, and to outline a solution to the problem.

Three years of such admissions to the Martland Medical Center, Newark, have been studied and summarized.

DEFINITION

IT IS important to have a yardstick for classification, since some treatment methods do not apply where lesser hemoglobin losses have occurred. Let it be said where less bleeding is involved it is more expedient, and statistically safer, to treat the patient by medical measures. Some definitions of massive upper gastro-intestinal hemorrhage depend on blood volume, some on the number of units of transfusion replacements, some on the number of Grams per cent of hemoglobin. The latter two are inaccurate when the physiology of blood regeneration is considered. However, they are the only practical standards for the average hospital. It is difficult, even in the largest and best equipped institutions to do blood volume studies on emergency cases on a twenty-four hour, seven-day basis. Therefore massive bleeding will be defined as that *lowering the hemoglobin to seven Grams or less or where*

*Read May 14, 1956, Surgical Session, Annual Meeting of The Medical Society of New Jersey.

five units of blood are needed for replacement. This is the definition suggested by Welch.[1]

INDICATIONS

The three major indications for early surgical intervention are (1) rapid, persistent bleeding, (2) recurrence of active bleeding and (3) massive bleeding in the older patient. The first is the least contentious. Patients may occasionally succumb to massive bleeding at any time of life. Recurrent bleeding has posed the question of whether to wait or whether, once experienced, the person should have surgery. Some clinicians have considered one recurrent episode as the criterion for surgery. From 25 to 40 per cent or more bleed a second time. Often the second bleeding is more severe than the first with a higher mortality. For these reasons many resort to surgery as an elective procedure in a quiescent period soon after the patient is able to withstand operation. This opinion impresses surgeons more than those partial to medical management who are so anxious to avoid surgery that they do not consider statistics as well as hospital days involved in those that survive.

Massive bleeding continues and is poorly tolerated in older people. Hence, it is generally agreed that surgery should be performed in this group with less time given to medical management. Only rarely does a patient under forty bleed to death. The likelihood of fatal hemorrhage, however, increases with age thereafter. This observation does not preclude the possibility of fatal hemorrhages in the young nor eliminate the possibility of recovery in the aged. However, this arbitrary age is used often to decide for surgery. All facts considered, older people should have early surgical intervention and should not wait for recurrent bleeding.

Several modifications pertain: gastritis and hiatus hernia usually do not cause as severe bleeding. This bleeding is slower and more likely to stop. Here temporizing may be tolerated. If the source is known to be duodenal ulcer early surgery is more urgently indicated as most of the bleeding occurs from this source. A low blood bank is also a reason for early surgery, as well as a patient with a rare blood type affecting available supply.

THREE YEAR SURVEY

AT THE Martland Medical Center, 365 cases of upper gastro-intestinal hemorrhage occurred in a three-year period. Of these, 119 were considered "massive total bleeding." Only 12 of these were women. In the entire series, 48 died—a fatality rate of 40 per cent in the "massive total bleeding" group, or 15 per cent in the entire series. Five of the fatal cases were in women.

Of those that could be classified as massive, duodenal ulcers accounted for 46 per cent of the total. The next two largest groups, esophageal varices and gastric ulcer, were responsible for an additional 37 per cent, almost equally divided between them.

Duodenal Ulcer	54	(46%)
Esophageal Varices	23	(20%)
Gastric Ulcer	19	(17%)
Unknown	14	(13%)
Gastritis	3	
Hiatus Hernia	2	
Duodenal Divert.	2	
Anastomotic Ulcer	2	
	119	

The remaining 23 cases were scattered among a number of causes, including 14 cases in which the source of the bleeding could not be determined. It can thus be seen that the problem of treatment mostly concerns three sources for the bleeding. The diagnosis and treatment of these three problems will encompass most of the patients in any institution, as these figures roughly follow totals reported elsewhere.

CAUSE OF DEATH

Esophageal varices accounted for the highest number of deaths:

Esophageal Varices	17	34%
Duodenal Ulcer	24	29%
Gastric Ulcer	10	21%
Unknown	6	14%
Carcinoma	1	2%
	48	100%

Duodenal ulcer, the commonest cause of massive bleeding, has the lowest mortality. Perhaps this is because its diagnosis and treatment have been better standardized in our hands. As indicated below the, highest mortality is in the patients who do not undergo surgery. Esophageal varices again are the worst offenders. All but two of those who died were not operated on.

Cause of Death	Surgery	No Surgery
Esophageal Varices	2	15
Duodenal Ulcer	4	10
Gastric Ulcer	5	5
Unknown	0	6
Carcinoma	0	1
	11	37

Many of these patients were received on the ward hardly alive. In spite of heroic measures, they could not be prepared for surgery. Five of the esophageal varices patients succumbed within the first six hours. Eleven died within 72 hours. Deaths from duodenal ulcers amounted to nine scattered over the same short period. In a large municipal institution, patients often wait until the last minute before seeking admission. The findings point up previous observations that some of these severe bleeders (so severe that the patient is exsanguinating under your eyes in spite of massive blood replacement) must be subjected to early definitive surgery with the hope of lowering this mortality. Such cases need careful deliberate forceful selection with large amounts of blood and good team play available. Three cases here included received over 20 units of blood in a short period, and yet succumbed soon after admission without surgery. They surely could not have fared worse if subjected to surgery.

TIME OF DEATH AND SOURCE OF BLEEDING

Time of death (Hours)	Source of Bleeding				
	Esoph.	Duodn.	Gastric	Unkn.	Total
0 to 6	5	1	1	1	8
7 to 12	0	1	1	1	3
13 to 24	1	2	0	0	3
25 to 48	3	3	0	2	8
49 to 72	2	2	0	0	4
Totals	11	9	2	4	26

MANAGEMENT

IF POSSIBLE before surgery is undertaken, the source of the bleeding should be determined. The admission history often reveals the source. If not, a barium swallow may prove helpful and has not proved harmful. Esophageal varices have been treated by the insertion of the double-bulbed tube of Patton and by surgical ligation. The number of successes is small, but it should be kept in mind as tube pressure does not necessarily control hemorrhage (Cases 1 and 3). Hemorrhage also may recur after its removal (Case 2).

CASE 1

Male, age 68, admitted in shock with massive hematemesis. Hemoglobin dropped within a few hours from 9.5 to 7 Grams per cent. The liver was easily palpable and thought to be cirrhotic. With diagnosis of bleeding esophageal varices, he was treated with multiple transfusions and the Patton tube which seemed to control bleeding. The patient died within 24 hours in severe shock from continued bleeding.

CASE 2

Male, age 49, was admitted to surgery with massive hematemesis and a hemoglobin of 5.8 Grams per cent. With an admission diagnosis of esophageal varices, he was treated successfully with the Patton tube, and received 25 pints of blood. A portal-caval anastomosis was later performed. On the first postoperative day he died of uncontrollable hematemesis.

CASE 3

Male, 55 years old, was admitted to the medical service with hematemesis; hemoglobin was 7.6 Grams per cent. He was treated with multiple transfusions and insertion of the Patton tube. He died five days later. Postmortem examination revealed bleeding esophageal varices from cirrhosis of the liver.

The two major causes of bleeding (gastric and duodenal ulcers) are better managed by early gastrectomy than by "point ligation" of a bleeding vessel. The latter method has been abandoned because it does not remove the underlying pathology and because recurrent bleeding too often occurs. Even following gastrectomy, bleeding has occurred in the remaining portion of stomach due to failure to resect the multiple sources. The duodenal stump should be suspect also, as illustrated by Case 4.

CASE 4

Male, age 55, admitted with a two day history of hematemesis and with a hemoglobin of 55 per cent. The day of admission a subtotal gastrectomy was done for continuing bleeding. Bleeding continued postoperatively. At a second laparotomy, the duodenal stump was examined for bleeding; none was found. Autopsy, six days later showed a residual bleeding duodenal ulcer.

Very careful examinations of the cardia of the stomach and duodenum are in order before the anastomosis is completed.

The next case shows that the cirrhotic person can have a peptic ulcer with two sources of bleeding.

CASE 5

Male, age 46, admitted to the surgical service in shock, with a hemoglobin of 7.5 Grams per cent and continuing hematemesis. A diagnosis of bleeding esophageal varices was made. He was treated expectantly with multiple transfusions and by Patton tube pressure. He died within 24 hours. Autopsy showed that, in addition to cirrhosis of the liver and the esophageal varices, he also had a bleeding peptic ulcer.

At a recent surgical conference a formula for management was adopted. Three main principles were enunciated: (1) All patients with massive upper gastro-intestinal bleeding should be admitted to the Surgical Service. (2) An immediate medical consultation (gastro-intestinal) is mandatory. (3) From this point, the diagnosis, management, and the optimum time for surgery, if indicated, is left in the hands of each service. At this conference the six attending surgeons were polled for opinion as to treatment under various circumstances. It is interesting to note the uniformity of these opinions, which, in most cases, was unanimous.

The problem of the *hemorrhage in a young patient who has a known ulcer* was considered. Best treatment was considered to be replacement of blood, general support, and medical management. Patients who *do not respond to support* in 7 or 8 hours and whose pathology is known were thought best managed by early operation as long as ample blood was available before surgery. In ulcer cases *over 45 years of age,* the opinion of all was for surgical exploration soon after restabilization with the performance of a subtotal resection. If these patients did not respond within 7 or 8 hours, immediate surgery even before stabilization is desirable.

Cases of *unknown etiology* were considered next. In the first hypothesis, those who do not respond in 7 or 8 hours, were considered best treated expectantly, with emphasis on making a diagnosis and the avoidance of surgery until such time. In cases of unknown cause where the patient did not respond in 7 to 8 hours, all voted for massive blood replacement with exploration. They wished careful exploration to be done at the time of surgery to determine the source, and wanted "blind gastrectomy" only as a last resort.

FOUR sets of circumstances led to disagreement as to the best method. In the patient over 45 with a known ulcer and first severe hemorrhage, who responded to support, four recommended an elective gastric resection. Two said that conservative expectant care was the best. Next considered was the problem of the second massive hemorrhage during the same admission, first of known duodenal origin and second of unknown origin. The patient with a second massive duodenal hemorrhage was unanimously treated by immediate supportive replacement and surgery. A second massive hemorrhage of unknown origin was treated by five with exploration. One wished to use conservative measures with a Patton tube, while an attempt at diagnosis was made. When a history of previous hemorrhage from a diagnosed duodenal ulcer was obtained, five proposed elective surgery after support, no matter what the age. One considered conservative management best if the patient were under 45.

Unresponsive known esophageal varices were the major cause of mortality in this series. Five surgeons concluded that they were best treated by early transthoracic ligation with the later use of one of the indicated shunt operations. The others thought that conservative care was still indicated in view of the high surgical morbidity and mortality in these cases.

SUMMARY

1. The problem of massive upper gastro-intestinal hemorrhage faces the profession today as a severe complication of three main causes: duodenal ulcer, gastric ulcer, esophageal varices. The 119 such cases studied at the Martland Medical Center during a three-year period constituted 32 per cent of all upper gastro-intestinal bleeding and suffered a 40 per cent mortality.

2. Each institution should analyze its resources including medical, surgical and laboratories, to determine what methods best suit their capabilities.

3. A careful integration of all facilities including an active blood bank is imperative.

4. Whether the choice of treatment is predominantly medical or surgical may be determined by an analysis of the existing facilities. The kind of patient admitted is also important.

5. Severe bleeding from esophageal varices remains the major source of concern and merits further consideration.

6. A uniform method of treatment should be adopted, after these facts are evaluated, if mortality is to be lowered.

161 Roseville Avenue (Dr. Hawkes)

Acellular Antigens in Treating Respiratory Infection

Shinefield* reports on a nine-year study on the use of autogenous acellular bacterial antigen complex (B.A.C.) in the treatment of infants and children suffering from recurrent respiratory infections and infectious asthma. The autogenous B.A.C. was made in the Hoffmann Laboratory, Paterson, N. J. These antigens differ from a vaccine in that they are acellular crystal clear solutions of all essential bacterial antigenic substances. These include those derived from the bacterial cell itself with its specific proteins and polysaccharides, as well as the very important metabolic products produced by organisms as they multiply *in vitro* and *in vivo*.

Shinefield* emphasizes the serious consequences of recurrent respiratory infections in infancy and early childhood, particularly the danger of an ensuing infectious asthma. Because of failure with antibiotics and other available medication, he began to treat these patients with vaccines in an effort to immunize against recurrent respiratory infections. At the start of his study he used commercial or autogenous vaccines which contained killed bacteria. Results of treatment with these ordinary vaccines was poor. He then tried autogenous B.A.C. preparations.

Of the 110 children treated with these new antigens, 90 per cent improved and 74 per cent became symptom free. In contrast, improvement was obtained in only 32 per cent of the patients treated with ordinary commercial vaccines.

The relief obtained with autogenous B.A.C. was prompt, and sometimes followed the second infection. Frequency, severity, duration and relapse rate were substantially reduced and only a few suffered any side effects.

*Shinefield, M.A.: New York State Journal of Medicine 56:1466 (May 1, 1956)

New Forensic Medicine Society

Medical jurisprudence . . . forensic medicine. . . medico-legal matters . . . or whatever other terms you use. If this interests you, come on November 21—a Wednesday—at 8:30 p.m. to the auditorium of the Rutgers Law School at 53 Washington Street, Newark. Purpose: to become a charter member of a new organization, The Medico-Legal Society of New Jersey.

Irving M. Riffin, M.D.

Max Block, M.D.

Montclair

General Anesthesia with Ultra-Short Acting Methitural Sodium*

Electrocardiographic Studies

With the recent upsurge of interest in the ultra-short-acting thiobarbiturates, attention has been directed to possible cardiac effects. In this workmanlike study, Dr. Riffin and Dr. Block find few e.k.g. disturbances during induction.

A new ultra-short acting intravenous anesthetic with a significantly more rapid recovery rate and fewer side effects than the older thiobarbiturates was first reported in 1954 by European investigators.[1,2] This drug, methitural sodium (Neraval® Sodium) is known as "Thiogenal" in Europe. On the basis of more than 10,000 cases induction has been reported to cause no significant changes in respiration, blood pressure or pulse rate.[3,5] Recovery time was found to be shorter than other barbiturates. Following ten-minute operative procedures, patients responded promptly,[6] being mentally alert and ready for discharge in from twenty to thirty minutes.[12] Vertigo, salivation, vomiting, numbness, tremors and excitement were notably absent during anesthesia and upon recovery.

The incidence of laryngospasm was negligible, although mild coughing during induction was noted among 5 to 10 per cent of the patients. The drug was well tolerated by patients of all ages and was found compatible with atropine, morphine, inhalation anesthetics and muscle relaxants.

Methitural sodium (Neraval® Sodium) is sodium, methylbutyl - (methylthio)ethyl - thiobarbiturate. This thiobarbiturate has unique properties, for it has a methylthioethyl radical in the -5- position. This radical is present in methionine, the essential amino acid which has been shown to have a protective action on the liver. The rapid detoxification and elimination of Neraval® is believed related to the presence of this methylthioethyl side chain.

Neraval® Sodium is a pale yellow, hygroscopic crystalline material with a strong sulfurous odor. It is freely soluble in water and yields a pH of 9.3 in a 5 per cent solution. Like other sodium thiobarbiturates, the aqueous solution is unstable and loses its potency fairly rapidly on standing.

Irwin[13] and co-workers found that methitural sodium possesses two-thirds the anesthetic potency of thiopental in the cat, dog and monkey. In equivalent anesthetic doses, however, they found recovery time with methi-

*Presented at the 190th Annual Meeting of The Medical Society of New Jersey, Section on Anesthesiology, May 15, 1956. The Methitural Sodium (Neraval® Sodium) used in this investigation was furnished by Kenneth Hawkins, M.D., Division of Clinical Research, Schering Corporation, Bloomfield, N. J.

tural sodium significantly more rapid than with thiopental, and cumulative actions to be considerably less than those observed with either thiopental or thiamyl. Similar observations have been reported in the United States [11] and in Europe.[15] Irwin [13] further demonstrated in a series of tests with dogs that when thiopental sodium and methitural sodium were administered daily, thiopental showed considerably more toxic effect on the liver than methitural.

METHOD

We have investigated in human subjects the cardiac effects of methitural sodium during induction anesthesia. Cardiac evaluation was based on instantaneous electrocardiographic tracings. These electrocardiographic studies comprise only one phase of interest. Other phases will be studied independently.

Methitural sodium was administered in induction anesthesia to 50 unselected cases covering a wide range of ages (10 to 81 years). Each received a total dose of 300 milligrams (5 cubic centimeters of a 6 per cent aqueous solution). All patients received secobarbital† grains 1½ and scopolamine grains 1/150 as pre-anesthetic medications. Induction time was comparable with thiopental and proceeded smoothly with minimum difficulties. Side effects incident to induction with thiobarbiturates occasionally were encountered. Transient coughing occurred more frequently than during thiopental induction.

With the patient on the operating room table control electrocardiograms were taken, including the three standard leads plus AVR, AVF and AVL. Subsequently, only lead two was taken continuously during injection of methitural and for two minutes thereafter.

RESULTS

Remarkably few electrocardiographic changes were recorded during induction with Neraval®. Of the total, 72 per cent showed no change from their pre-anesthetic, control records. The most common finding, seen in 8 per cent, was flattening of the T wave with recovery to the control T wave voltage in 2 minutes. Tachycardia in addition to flattening of the T wave, with recovery in 2 minutes, was observed in 6 per cent of the cases.

The remaining changes were seen in single cases. These included sinus arrhythmia, flattening of the T wave without recovery in 2 minutes, lowering of the QRS complex from 10 to 3 millimeters, sinus arrhythmia with flattening of the T wave and recovery after 2 minutes, paroxysmal auricular tachycardia with recovery in 2 minutes, and prominent, upright T waves. In one case, premature ventricular contractions occurred immediately after injection, followed by recovery in 2 minutes to a normal tracing with no premature ventricular contractions.

The electrocardiographic changes observed in our series were minimal and transitory. We observed less respiratory depression and less cardiac acceleration with methitural sodium than had been noted previously with the other thiobarbiturates. The new anesthetic was well tolerated by patients of all ages.

The incidence of these changes compares favorably with the frequency of such electrocardiographic abnormalities observed during thiopental or thiamylal anesthesia. In observations made on 10 of our patients during induction with thiopental, 6 showed similar electrocardiographic changes.

Gruber [16] first drew attention to the effects on cardiac rhythm of thiobarbiturates employed as anesthetic agents in laboratory animals. Kohn and Lederer,[17] using dogs, cats, rabbits and monkeys, noted depression of the T wave following both thiopental and hexobarbital*. They found electrocardiographic disturbances, if present, disappeared without exception at the end of anesthesia. Recently, Irwin, Stagg, Dunbar and Govier [13] made similar observations in their comparative study of the actions

†We used the Lilly brand tradenamed Seconal®.

*They used the Winthrop-Stearns brand of hexobarbital tradenamed as Evipal® and the Lilly brand of amobarbital tradenamed Amytal®.

of methitural and thiopental in the cat, dog and monkey.

Although extensive research has been done in evaluating the cardiovascular effects of thiobarbiturates on laboratory animals, few studies have been conducted with human subjects. Burstein, LoPinto and Newman [18] reported no electrocardiographic changes in four out of five patients during anesthesia, using relatively large doses of thiopental. The fifth case, however, showed a depressed ST segment and decrease in the voltage of the T wave lasting for two minutes.

In another study, Burstein, Woloshin and Newman [19] found a significant decrease in the voltage of the T wave in two out of four patients after injection of thiopental, lasting 10 to 15 minutes. Volpitto and Marangoni [20] found no deviation from the normal in QRS, P-R interval or T wave in their series when either thiopental, hexobarbital or amobarbital* was used. Fieldman [12] recently reported electrocardiographic changes in one patient whose blood pressure increased suddenly to 210 under thiopental anesthesia.

Most investigators attribute electrocardiographic disturbances to the decreased pulmonary ventilation produced by the intravenous administration of thiobarbiturates. Rosner, Newman and Burstein [22] state: "When respiratory tidal volume was diminished following administration of thiopental sodium, decrease in voltage of the T wave and depression of the ST segment often resulted. This was interpreted as being due to cardiac ischemia resulting from diminished ventilation." Rosner *et al.* believe the incidence of electrocardiographic disturbances can be reduced by avoiding hypoxia. They state, "All the disturbances were transitory and disappeared with adequate oxygenation." However, Gruber, Gruber and Kwang,[23] feel that the cardiac irregularities, though they may be due to tissue anoxia, do not depend on general anoxia due to respiratory failure alone. They state, "The local cardiac tissue anoxia is due to at least three factors: vaso-constriction of blood vessels, increase in general arterial blood pressure, (this increases the load on the heart, thereby increasing the metabolites and decreasing the relative oxygen supply in the muscle cells) and third, and perhaps the least active cause, is decreased respiration."

Gruber [23] *et al.* point out that animals under adequate artificial respiration continued to show arrythmias. These authors consider increased arterial blood pressure to be of greater importance than hypoxia in the production of electrocardiographic changes in thiobarbiturate anesthesia.

Fieldman,[21] on the other hand, reports a fall in arterial blood pressure during induction anesthesia with thiopental as have other investigators. He further states: "A greater fall in blood pressure was observed during a rapid induction as compared to a slower induction," and concludes that slow induction is the method of choice. Fieldman [21] also reports a decrease in cardiac output paralleled by a decrease in stroke volume and in central blood volume. Decrease in arterial oxygen saturation was observed by Fieldman in all patients in whom induction was attempted while the patients breathed room air. In patients who received oxygen prior to induction with thiopental, no fall in arterial oxygen saturation was observed. Fieldman [21] concludes that " . . . it would be advisable to utilize oxygen pre-operatively especially if other agents such as curare are used which depress respiration."

Despite discrepancies and contradictory reports on the factors producing the electrocardiographic disturbances observed with thiobarbiturate anesthesia, the weight of evidence points to hypoxia due to respiratory depression as the underlying mechanism, rather than to any cardiotoxic effect.

SUMMARY

1. A new ultra-short acting intravenous anesthetic, methitural sodium (Neraval® Sodium) was found to cause remarkably few electrocardiographic disturbances during induction anesthesia when administered to 50

unselected cases covering a wide range of ages (10 to 81 years).

2. Of the total, 72 per cent showed no change from their pre-anesthetic control electrocardiograms.

3. The most common finding, seen in 8 per cent of the cases, was flattening of the T wave with recovery to the control T wave voltage in 2 minutes. Tachycardia in addition to T wave changes with recovery in 2 minutes was observed in 6 per cent of the cases. The remaining cases consisted of single instances of various arrhythmias and one case in which the amplitude of the QRS complex decreased from 10 to 3 millimeters.

4. The electrocardiographic changes observed were minimal and transitory. Less respiratory depression and less cardiac acceleration were observed with methitural sodium (Neraval® Sodium) than with the other thiobarbiturates. It was well tolerated by patients of all ages.

5. Hypoxia due to respiratory depression, rather than direct cardiotoxic effect, seems to be the underlying cause of these electrocardiographic disturbances observed.

419 Park Street

A bibliographic listing of 23 citations from the world's literature will be found in the authors' reprints.

Acellular Bacterial Antigen Complex in Respiratory Infections

Spielman* describes results with a new acellular bacterial antigen complex (B.A.C.) in 50 patients with recurrent respiratory infections, infectious asthma or acute sinusitis. These antigens prepared in the Hoffmann Laboratory, Paterson, N. J. contain the intracellular and surface elements of the bacteria as well as the toxins present in the bacterial culture filtrate. In most of the patients treated, immediate wheal reactions were obtained on intracutaneous injection. Of the 50 patients treated, excellent results were obtained in 25, good in 15, fair results in 7 and poor in 3. Spielman* attributes these results to the ability of these acellular B.A.C. preparations to immunize the patient against recurrent infection and to desensitize him against the bacterial antigens including the specific substances and the toxins present in the bacterial filtrate.

The author compares these new antigens with ordinary vaccines. He says that routine methods frequently remove valuable antigenic components necessary for immunization and desensitization. He also emphasizes that the indiscriminate use of *antibiotics in these patients may prevent development of immunity.*

Spielman* concludes that his good results are due to the fact that the new acellular B.A.C. used in his study are more complete and therefore more effective. No significant side-effects were noted. There was no need for the use of antibiotics.

*Spielman, Aaron D.: New York State Journal of Medicine 55:1603 (June 1, 1955)

Do You Have to Work with Lawyers?

If so, you might be interested in helping establish a medico-legal society here. The organization meeting is scheduled for Wednesday, November 21 at 8:30 p.m. at the law school, 53 Washington Street, Newark. No preliminary registration. Just come and introduce yourself.

George P. Koeck, M.D.

Newark

Cobalt Radiotherapy*

Exciting and challenging possibilities in cancer therapy have been opened by the development of the simple cobalt^{60} machine for producing gamma rays. It is relatively nontoxic to skin and delivers high, accurately placed dosages of radiation.

Since the discovery of Roentgen rays in 1896, there has been a fabulous, rapid advancement in the use of the gamma ray as a source of energy in cancer therapy. In 1913, the Coolidge x-ray tube led to the first big step toward good radiotherapy. Then, soon after World War I, with the development of 200 KVP† apparatus, radiotherapy began to produce many more satisfactory clinical results.

Today, the 200 to 250 KVP† machines, although great instruments of therapy, are limited in treating tumors that are deep in the body, and those that require high tumoricidal doses. This is so because the quality of the treatment beam of these machines is such that a much greater dose is unavoidably given to the normal cells above and all about the tumor area. The dose to these normal cells at times produces irreversible changes in tissue, so that death, fibrosis, scarring, skin tanning, telangiectasia, and abnormal functions in organs may result. Such is the case, at times, if a permanent destructive dose is to be delivered to the tumor area. These results are not frequent, however, for many of these sequelae can be avoided by the use of multiple portals of treatment plus exact technics of time and dose. Then the normal tissues receive only one-fourth or one-sixth of the dose that a single portal of entry would deliver. Careful planning, calculation and positioning are necessary. Sometimes it is not possible to use as many different portals as would be desirable. This applies especially to head and neck treatment, to therapy over bony areas, and over vital tissue such as the lung, bladder, rectum and small intestinal tract. Thus a tumoricidal dose may be difficult to obtain or fraught with danger when completed. These, then, are some of the limiting factors inherent in conventional 250 KVP† therapy.

Radium has been in use since its discovery by the Curies, and has been a valuable agent in cancer therapy. Its use, however, has been confined largely to interstitial implantation in tissue, or in close contact with structures or disease on body surfaces or in body cavities. Many large sources of radium for use in teletherapy have been impossible, because there is not enough available radium in the world for such utilization. Even if there were, its cost would be prohibitive.

The ideal in radiotherapy is the application of a beam of energy that will bring about complete destruction of cancer cells at any chosen depth in body tissue and, at the same time, preserve the normal tissues above and about the tumor area. The treatment beams produced by supervoltage (one-, two-million volt x-ray ma-

*From the Black-Stevenson Clinic of the Presbyterian Hospital in Newark.

†The abbreviation KVP means Kilovolt Peak.

chines, cyclotron and radioactive cobalt) have manifested these desired qualities to a great degree. Although this is not the ideal, it approximates it better than any other form of present radiotherapy.

Radioactive isotopes of various types have been eagerly studied with the hope of producing this ideal of treatment. In the search for this isotope, certain qualities inherent in the material are necessary:

(1) It must be a gamma ray emitter.
(2) It must have a fairly long half-life.
(3) It must be plentiful.
(4) It must be relatively inexpensive.

Of the substances studied, cobalt ^{60} answered all the necessary demands. It emits a gamma ray having the equivalent energy of radium or a two to three-million volt x-ray machine. It has a half-life of 5.3 years. This means that, if we start with 1000 curies of cobalt ^{60} in 5.3 years we will have 500 curies remaining, and so on. It produces no harmful gases or by-products. It can be produced to high intensity so that a source can be had to contain 2000 to 3000 curies. This is an amount of available energy never possible before in so many places, even if a world-wide accumulation of radium were made for use in similar treatment.

It is plentiful, so that an unlimited number of sources may be activated in numerous atomic piles. Another important characteristic of cobalt ^{60} is the never-changing quality of its energy. Even though the amount of available active substance is constantly decreasing, its penetrating, purified tissue-sparing beam never changes. This means that it can penetrate tissue with much less effect on surface and superficial tissues than 200 to 400 KVP† apparatus. It also means that it can deliver a greater dose of energy deeper in the body than the ordinary x-ray machines. It is possible, therefore, to deliver a greater dose to the underlying tissues with less effect on the skin or superficial tissues. This may be the difference of being able to safely administer a tumoricidal dose with control of disease or only producing palliation for many deep-seated tumors.

The skin, which is a limiting factor for dosage with 250 KVP† machines, is markedly spared by cobalt.^{60} Rarely is more than a moderate reaction seen on skin through which cobalt ^{60} is directed. Another big advantage of the cobalt ^{60} energy beam is its small absorption factor in bone. Possibility of bone necrosis often limits dosage with conventional x-ray therapy and, hence, limits doses necessary for permanent cancer destruction. This refinement is especially important in head and neck cancer where bone is an integral part of tissue surrounding these lesions. Its sparing effect can also be readily seen in pelvis tumors or in masses close to or actually inside bone.

THE integral dose, meaning the total body effect, of cobalt,^{60} is much less than in the 250 to 400 KVP† range. Consequently, nausea, vomiting, bone marrow depression and lassitude are mostly non-existent. The chief effect of this treatment beam is, therefore, sharply localized and confined, while the general body receives very little effect. This promotes better therapy planning without interruptions or without depressing the patient's general condition during treatment.

The cost of a cobalt ^{60} teletherapy unit, in contrast to a two- or three-million volt x-ray machine, is much less: only about one-fifth. The cobalt machine is simple, having very little mechanical construction. Only exceptional periods of breakdown or inactivity ever occur. It is small and can be contained in average-sized rooms. Ease of maneuverability greatly enhances rapid set-ups of patients for therapy. The active cobalt ^{60} isotope is so housed that it is perfectly safe to working personnel and patients alike. Simple safety devices prevent possible injury if breakdown ever occurs.

How can we take advantage of these excellent radiation features? To briefly summarize the above improvements, we find that cobalt,^{60} used as a source for teletherapy, has:

(1) A gamma ray beam capable of deep tissue penetration equal to that of the two- or three-million volt x-ray machines.
(2) Very little skin effect.
(3) Bone absorption no greater than that of surrounding soft tissue.
(4) Negligible integral dose or general body effect.

(5) Sharply outlined beam.
(6) Power of delivering necessary doses to cells in any part of the body through a minimum number of portals.
(7) Power to render tumoricidal doses to deep tumors easily.

Specifically then, we can expect better therapy with a resultant survival rate improved, and with much less local or general reaction when cobalt ^{60} therapy is used. In head and neck cancer, better controlled doses to tumor areas are possible. Bone necrosis and/or skin reactions are of negligible concern. Full tumoricidal doses are better planned and more accurately delivered. Smaller sources of cobalt ^{60} (500 to 1000 curies) are admirably adapted for head and neck treatment because short source-skin arrangements can be used. Treatment cones, too, are now made that enable close and accurate alignment of the therapy beam with the tumor area. Post-radiation surgery is easier. There is very little skin reaction after cobalt therapy. Healing of tissue is normal with no complications.

IN THE deep confines of the bony pelvis, where the bladder and rectum often limit proper dosage to growths arising in the urinary, rectal or genital tracts, we have a definite advantage with cobalt ^{60} therapy. It is possible at this site to deliver through the skin, doses large enough to produce sterilization of tumor cells. In conventional therapy, the skin is very often a limiting factor in delivering proper doses to the deep bony pelvis. Then, reactions in the bladder and rectum are likely to be more severe with the 250 KVP† range of kilovoltage. This does not mean that in the 250 KVP† level good and proper therapy cannot be given, for it can, and has been for years. But, with cobalt,^{60} there is less injury to the skin, bone and deep tissues and, at the same time, better localization and delivery of a tumoricidal dose to cancer areas. This applies especially to cancer in the lateral pelvic walls where a proper dosage is often difficult to deliver.

In retroperitoneal tumors, these advantages are all readily apparent. There is frequent nausea and vomiting when large doses of x-ray are directed through the epigastrium. With cobalt ^{60} this is markedly minimized or entirely absent. This is often a factor in maintaining proper body balances during therapy. At the same time, knowledge of cobalt ^{60} dangers, deep in tissue, is necessary, for, while the skin appears free from reaction and the patient's general behavior is fine, effects not seen in the spinal cord, intestinal tract and subcutaneous tissues are occurring and must be properly regulated.

Dosages, therefore, are not limited by skin effects, but more accurately by deeper tissues and tumor effects. Knowledge of side effects is essential for, if guided by the skin alone, overdosage to subcutaneous, nerve or intestinal tissue can easily occur. These, however, are minimal when compared with the effects of 250 KVP† when the tumor dose is the same.

In the chest, cobalt ^{60} therapy has definite advantages. Tumors here are usually located deeply. They are surrounded by vital structures. Lung, pleura, bone, trachea, esophagus and vertebral bones are affected, either directly or indirectly, by radiation doses necessary to destroy adjacent cancer. These effects, however, are much less with cobalt ^{60} therapy than with conventional therapy beams. Thus it is possible to deliver a more accurate tumor dose with less side effect.

In the treatment of carcinoma of the breast, cobalt ^{60} probably offers great advantages inherent in the quality of its beam. Since skin reactions are the greatest drawback in treatment with 250 KVP† apparatus, a major benefit can be seen when using cobalt ^{60} with its great skin-sparing effect. This can be of definite benefit when treating either operable cancer before or after surgery, or inoperable breast cancer. The side scatter into the lung parenchyma when using oblique fields, too, is much reduced.

CONCLUSION

WE NOW have a simple mechanical instrument with a powerful beam of gamma rays. In its application to human tissue, it possesses definite advantages. These permit more accur-

ate radiotherapy, so that close to an ideal in this treatment is present. It has much less reaction in skin, bone and the body as a whole. It can deliver higher, more accurate tumor doses, especially in the deep tissues of the body. These, however, must be applied with the skill and care necessary in any therapy plan. The modes of treatment with 250 KVP† apparatus are still valuable and efficient. Cobalt ^{60} in certain deeply located tumors has definite advantages. Also, carcinoma enclosed by bony or more sensitive tissues can be better treated by the cobalt ^{60} beam. It is possible to destroy some types of cancer with a cobalt ^{60} teletherapy machine that could not be destroyed by a 250 KVP† machine. Treatment can be delivered safely, accurately and effectively.

Cobalt ^{60} therapy does not displace surgery where indicated. In such areas as stomach, colon, rectum, breast, bone, brain, et cetera, surgery is still the best primary method of treatment.

†KVP means kilovolt peaks.

161 Roseville Avenue

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A Time for Thankfulness

November is a month for giving thanks, for counting blessings. It is a time for giving. High on every good citizen's list of beneficiaries are the health, recreation and family welfare agencies included in United Fund and Community Chest campaigns. The services they provide are everybody's blessings.

Youth agencies helping boys and girls grow up to be responsible men and women, leisure time activities for both old and young, protective care for babies, health programs providing life-saving research and care for the ill and handicapped . . . they are the things for which every community-minded citizen gives generously according to his ability. The service and the ability to give are things for which we all give thanks.

At this time of Thanksgiving, totals are being taken on the funds contributed to this fall's campaigns for the support of the nation's humanitarian services. The amount of money raised will determine how far their good works can be extended in the year to come.

Now is the time to make sure your town can provide its people with the blessings of adequate health and welfare services. This is the time to give thanks for the gift and the giver. Have you given your share?

Irvin Sussman, M.D.

Bridgeton

Acute Glomerulonephritis*

Unless serious complications occur, treatment for acute glomerulonephritis should not be too vigorous, in Dr. Sussman's opinion. The physiologic pathology of this disorder is briefly reviewed in this compact monograph.

A husky 200-pound male telephone lineman, age 25, was admitted to Salem Hospital on March 16, 1955. He presented a typical picture of acute nephritis with complaints of right flank pain, nausea and vomiting. He had had an acute respiratory infection associated with a very bad sore throat four weeks prior to the onset of his present symptoms. He had suborbital edema and a generalized puffy appearance. Blood pressure was 158/110.

Initial laboratory studies revealed four plus albuminuria with occasional granular casts. The urine was loaded with red cells. Leukocyte count was 13,500 with a normal red cell tally. Blood urea nitrogen was 60 milligrams per cent. Sedimentation rate was 39 millimeters in one hour. Electrocardiogram, chest x-ray and blood proteins were normal.

For the next five days, his condition became progressively worse with a rise of blood urea nitrogen to 111 and creatinine to 10. He became disoriented, restless and lethargic. Three and four plus albuminuria persisted. He suffered some oliguria with urine output only 250 cubic centimeters on the fifth hospital day. Blood pressure remained at 160/104.

He then developed a spontaneous diuresis with a loss of 11 pounds in the next six days. On the eleventh hospital day, his blood urea nitrogen had fallen to 34. Four plus albuminuria, cylinduria and hematuria persisted. On the next day, he insisted on signing his release against advice. Eight months later he was re-admitted for two days for cystoscopy and intravenous pyelogram which were both normal. His blood urea nitrogen and urine were within normal limits.

Although most investigators[1] believe that acute glomerulonephritis represents some type of immunologic response, its exact mechanism is not precisely known. The beta-hemolytic streptococcus Group A, type 12 has been incriminated as the precipitating infection in the great majority of cases. Other types have also been isolated. All have some type of nephritogenic property. Latent period after the original streptococcic infection may vary from a few days to four weeks. In Weinstein's series[2] of 2000 cases of untreated scarlet fever, one per cent of the patients developed glomerulonephritis.

PHYSIOLOGY AND PATHOLOGY

The pathology[3] consists of a diffuse capillaritis of the glomerular loops with thickening, reduplication and granular fibrinoid alteration of the capillary basement membrane. The obstruction of the glomerular capillaries is usually caused by an increase in the number and size of the capillary endothelial cells. In some instances, the piling up of the epithelial crescent may also cause some degree of obstruction.

Although many postulates have been pro-

*Presented May 16, 1956 at the Annual Meeting of The Medical Society of New Jersey.

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posed to explain the hypertension in these cases, its etiology has not been exactly defined. The edema[4] is produced by the interplay of many mechanisms and their relative roles are also not exactly defined or agreed upon. They include increased capillary permeability, salt and water retention, glomerulotubular imbalance, heart failure and lowered colloid osmotic pressure.

The proteinuria and hematuria are a direct result of the capillaritis. The decrease in glomerular filtration rate as measured by inulin clearance is caused by thickening of the basement membrane and endothelial cell proliferation which in turn may result in azotemia. The tubular function is very slightly altered.

Hypertensive encephalopathy may appear. The relation of the hypertension to the encephalopathy is again not fully explained. Frequently cardiac enlargement is seen in the first week or two. Gore and Saphir have demonstrated a serous myocarditis.[5] Electrocardiographic abnormalities with lowering of the T waves in lead I and precordial leads may frequently appear. Although the hypertension may precipitate the heart failure, heart failure may be present in the absence of hypertension. The exact pathogenesis of the heart failure[6] also remains obscure.

Renal failure may be due to glomerular obstruction with reduction of glomerular filtration rate, salt and water retention, heart failure and severe vomiting.

DIAGNOSIS

THE diagnosis of acute glomerulonephritis may be very easy when overt phenomena such as gross hematuria, edema, hypertension, cerebral phenomena, oliguria and anuria appear. However, one investigator[2] reports that the disease is recognized in only one out of twenty cases. Patients with subclinical cases need a urinalysis weekly for three or four weeks after each streptococcic infection in order to pick up all who have acute glomerulonephritis. Bell[3] states that albuminuria must be present and is a constant finding in all cases of glomerular nephritis. Even a slight injury to the glomerulus makes it permeable to protein.

In the differential diagnosis one should consider exacerbations of chronic nephritis and benign hemorrhagic nephritis after infections. Benign hemorrhagic nephritis has none of the proliferative features of acute diffuse glomerulonephritis nor the sequellae.

PROGNOSIS AND TREATMENT

IN GENERAL, the prognosis is good. Ninety to 95 per cent recover. Three to five per cent may die. This usually occurs during the first week from the complications. Two to five per cent may become chronic. If the patient is going to develop the chronic phase, the latent period is usually not over a year or two. The older the patient, the more likely he is to develop the chronic form. Age does not influence the mortality. The mortality is directly related to the complications (cardiac, encephalopathic and anuric). However, if the patient recovers from these complications, then the prognosis becomes the same as for other cases of acute glomerulonephritis without complications.

Treatment is directed mainly toward prophylaxis and management of the complications.

There is some debate as to the effectiveness of penicillin prophylaxis. Rammelkamp[7] recently reported his impressions of prophylactic treatment especially during epidemic phases of the disease. He advocated 600,000 units of Benzathine penicillin to contacts to limit the spread of the disease. However, he admits that this is not nearly so effective as with rheumatic fever and it certainly does not prevent all cases from occurring. This form of penicillin

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has been advocated in chronic nephritis to prevent the exacerbation from recurrent streptococcic infection.

Patients should probably be kept at complete bedrest for at least the first week and as long as there is any evidence of edema, heart failure or hypertension. This rest should be continued until the urinary symptoms are stabilized if not completely gone. The urea clearance is probably the best index for return to activity and if the urea clearance starts to improve in two or three weeks, then return to activity can be initiated. If it is normal at the end of four to six weeks, the patient can probably be returned to school. Chronic forms of the disease are rare after the urea clearance returns to normal. However, it is usually six months before the Addis count becomes normal.

In general, a low protein and low salt diet is recommended. Fluids are usually limited to the urinary output plus one liter for insensible loss. After disappearance of the edema, oliguria, and hypertension, diet and fluids may be increased. Any diet may be used if there are none of these factors originally present. A daily weight may show some edema during the first few days followed by spontaneous diuresis.

Antibiotics [8] have no direct effect upon the glomerulonephritis, but may be used to treat any remaining infection or to prevent recurrent infection. One has to be quite careful [9] in the use of these drugs in the presence of oliguria and anuria.

Antihistaminics and corticosteroids have been of no proved value.[10]

Heart failure may be rapid in its onset. Treatment is the same as for heart failure in any other instance except that alertness and prompt institution of therapy are required.

Hypertensive crisis may be responsible for precipitation of the heart failure. The physician should be alert to the early signs of encephalopathy which include headache, nausea, vomiting, irritability, apathy, drowsiness, paralysis or visual disturbances.

Magnesium sulfate probably remains the most effective drug in the treatment of hypertensive crisis. In addition it has the advantage of increasing plasma flow and glomerular filtration rate in the presence of hypertension. Intravenous administration is the most effective method especially in the presence of severe encephalopathic symptoms. It may be as a 1 or 2 per cent solution or, in extreme cases, one may try 20 cubic centimeters of 10 per cent intravenous solution given very slowly. If the patient has oliguria, magnesium sulfate may be toxic and slowing of the respiratory rate should be watched for. The doctor should keep on hand an antidote of 10 per cent calcium gluconate. Dose is 10 cubic centimeters. Other measures include the use of hydrazinophthalzine†, veratrum alkaloids, venesection and, of course, sedation to control the manifestations of cerebral irritability.

Treatment for *anuria* should not be too vigorous. The practitioner should wait two to seven days for spontaneous relief and diuresis. Diuretics should not be used. Fluids should be restricted from 800 to 1000 cubic centimeters. The diet should be high in calories and carboyhdrates and low in potassium and protein. The high caloric diet is utilized in an effort to spare the endogenous breakdown of proteins with further release of the end products or protein catabolism. Supplementary high caloric substances such as Lipo-Mul®, Ediol® or glucose, peanut oil and water emulsion mixtures given by nasal catheter have also been used. Infection should be avoided. Retrograde catheterization should be used if there is any question of ureteral obstruction. Strict attention is paid to electrolyte balance with frequent determinations of the nitrogen, urea, and carbon dioxide combining power, blood sodium, potassium and chloride, with restoration towards normal as indicated. Packed red blood cells may be used for treatment of the anemia.

†Commercially available under the Ciba tradename of Apresoline®.

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Malignant Tumors of Small Intestine*

Gastro-intestinal complaints are the common currency of medical practice today. In this stomach-centered culture, the gastro-intestinal tract is the prime sounding board of emotions. Most gastro-intestinal disorders turn out to be of no serious organic import. This lulls many of us into a sense of false security about the prognosis. This timely paper is a reminder of the grave possibilities.

Malignant tumor of the small intestine is rarely thought of in patients with gastro-intestinal complaints or melena.[3] In the two cases presented below, and in another case reported at St. Francis Hospital, Trenton,[2] the diagnosis of small bowel malignancy was not entertained pre-operatively. This seems to be a common error.

The patient with small bowel malignancy will usually have some degree of obstruction or anemia following blood loss into the small intestine.[1] In both our cases and in the leiomyosarcoma referred to above,[2] there was blood in the stool, and in one there was constipation. Rarely there may also be perforation or intussusception. Often there are anorexia and weight loss.[3]

Sarcoma is frequently palpable.[3] If there is obstruction high in the small intestine, vomiting may be an early sign. If there is obstruction low in the ileum, distention may be found. Perforation will cause the usual board-like abdomen. Grossly tarry stools may be observed.

The incidence of malignant tumors of the small intestine among gastro-intestinal malignancies was 5 per cent in a series of 776 cases. This included leiomyosarcoma, adenocarcinoma, carcinoid, lymphosarcoma, fibrosarcoma and others.[4] In another series the distribution was 54 per cent adenocarcinomas to 39 per cent lymphosarcomas.[1] There appeared an equal distribution between males and females with no special decade [4] of preference.

In the duodenum, carcinomata of the periampullary region are found. The upper third of the jejunum and the lower third of the ileum are common sites for carcinoma. Anderson [5] places half the carcinomata in the duodenum and the other half in the jejunum and ileum. These bleed easily and have a tendency to form nodules or constricting annular rings. Sarcomata vary greatly as to size, degree of extension and relation to lumen. They may transform the lumen into a hard rigid tube.[3] Metastases were found in 90 per cent of autopsied

*From the Pathology Department, St. Francis Hospital, Trenton, New Jersey. Dr. Ryan is a resident in surgery.

1. Bostford, T. W. and Seibel, R. E.: New England Journal of Medicine, 236:683 (May 8, 1947)
2. Kustrup, J. F. *et al.*: Journal of the International College of Surgeons, 4:476 (April 1955)
3. Cameron, A. L.: Annals of Surgery, 108:203 (August 1938)
4. Ackerman, L. V. and del Regato, J. A.: *Cancer: Its Diagnosis and Prognosis.* Ed. 2. Pages 579 through 593. St. Louis, 1954. Mosby.
5. Anderson, W. A.: *Pathology.* Ed. 1. Pages 850 through 853. St. Louis, 1948. Mosby.

cases. These should be looked for in the liver and on the peritoneal surfaces.

Small bowel studies should be made on every patient with suggestive symptoms[1] unless an adequate cause is found in stomach or colon. One may find a small bowel pattern with "step-laddering," stenosis of lumen or a rounded filling defect.

Radical surgery is needed. This would include resection of the segment of intestine with its mesentery and re-establishment of continuity of bowel. In the duodenum, a type of Whipple resection for carcinoma of the ampulla of Vater might be tried.[1] Removal of secondary seedings may be indicated.[6] X-ray therapy is indicated for all lymphosarcoma and possibly for leiomyosarcomas postoperatively.

Average survival rate[1] was eleven and a half months for adenocarcinoma and six months for lymphosarcoma in twenty-two patients who received surgery. The prognosis with leiomyosarcomata as with lymphosarcomata varies directly with the anaplasia of the tumor.

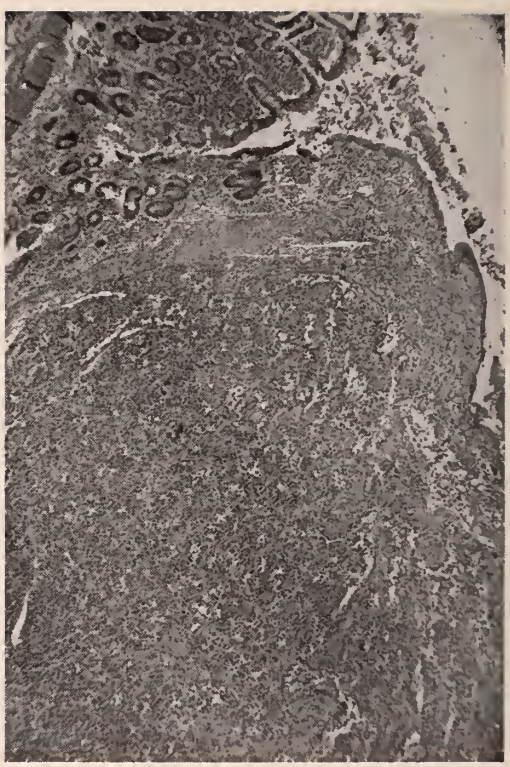


Figure 1. Anaplastic carcinoma of jejunum.

CASE ONE

This 52-year old woman was admitted August 11 with indigestion, weight loss, weakness, confusion and headache. She passed tarry stools. A provisional diagnosis of duodenal ulcer was made.

No gross abnormalities were found on admission. There was questionable weakness of the left arm. A doubtful Babinski on the left side was reported. X-ray revealed only faint evidence of a lesion of the upper pars media on the greater curvature. The skull was normal. The electroencephalogram was consistent with a diffuse degenerative disease of the brain. Hematocrit was 32: hemoglobin 10 grams. Urine was normal. Stool was positive for occult blood.

On August 25 a transverse epigastric incision was made, but no lesion could be palpated in the stomach. A mass was palpated, however, lower in the intestine. A different hypogastric linear incision was made and a mass in the small intestine with extension to the left colon was identified and resected.

Figure 1 reveals the microscopic section of the jejunum at the zone of transition between the normal mucosa and the anaplastic carcinoma. This pear-shaped mass was identified microscopically as a papillary adenocarcinoma of the small intestine with invasion of all layers and metastatic extension to the serosa of the colon.

Patient was discharged on September 10 but was readmitted on September 21, nearly comatose. Hemoglobin at that time was 83 per cent. She died on September 28. Autopsy revealed a well-functioning anastomosis of the jejunum five feet from the ligament of Treitz and another functioning anastomosis of the left colon. A 6 centimeter brown tumor, occuping most of the anterior aspect of the right lateral ventricle of the cerebrum was found. Microscopically this revealed anaplastic carcinoma with signet-ring cells, characteristic of gastro-intestinal carcinoma. See Figure 2.

CASE TWO

This 65 year old man was admitted November 3. He complained of constipation of five days and of having passed a black stool in the previous week. He also complained of an incisional hernia at the site of an old laparotomy. On examination, a huge ventral hernia was identified. There also were suppurating nodes in the right groin and a 1.75 inch mass in the right lower quadrant with multiple subcutaneous nodules. Rectal examination revealed no masses. Blood-urea-nitrogen was 51 milligrams per cent. Creatinine was 4.6. Stool was positive for occult blood. Hemoglobin was 12 Grams. A biopsy of the abdominal wall mass was done and a diag-

6. Starr, G. F. and Dockerty, M. B.: Cancer, 8:101 (1955)

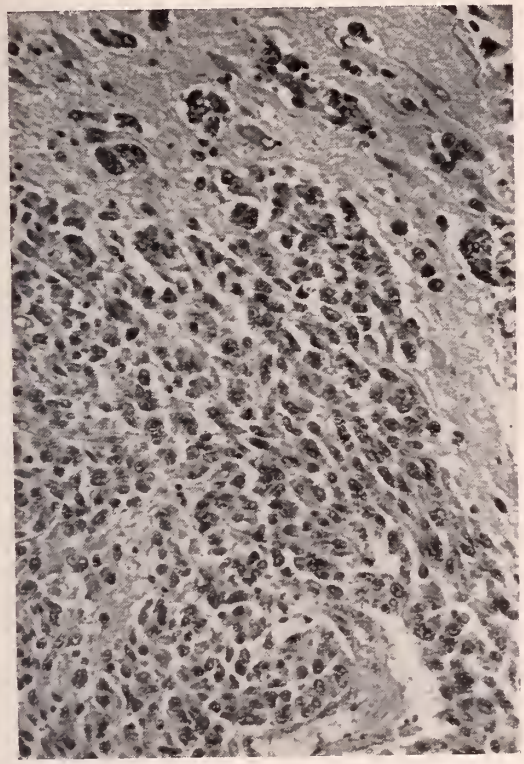


Figure 2. Metastatic carcinoma of cerebrum.



Figure 3. Lymphosarcoma of ileum.

nosis of a markedly anaplastic carcinoma of the abdominal wall was made.

On November 13 he died. At autopsy an elevated tumor with a central crater was found in the ileum, four feet from ileocecal valve. Another raised nodule 7 centimeters from this was found. Metastatic tumors of the lungs, diaphragm, thoracic wall, axilla and inguinal lymph nodes, liver, kidneys and adrenals were found grossly.

Microscopic examination of the craterous elevated lesion of the ileum revealed a lymphosarcoma, as did the metastatic lesions. Figure 3 is a low power magnification of the section of ileum at the site of the tumor. Cross section of villi can be seen. The muscularis is entirely replaced by lymphosarcoma.

1. Neoplasms of the small intestine must always be kept in mind in patients with gastrointestinal complaints, obstruction and/or melena, especially when an adequate cause is not found in the stomach or colon.

2. Small bowel roentgenographic studies should be made to substantiate the impression of small bowel tumors.

3. Only earlier diagnosis with resection will improve the grave prognosis associated with small bowel malignancies.

Acknowledgment is hereby made to Dr. Gilbert of the N. J. State Laboratory for the microphotographs.

601 Hamilton Avenue

Historical Article • • •

Fred B. Rogers, M.D.
Trenton

Ezra Mundy Hunt: 1830-1894

Pioneer of Public Health*

In an interesting, New Jersey-oriented, historical vignette, Dr. Rogers tells of the pioneer work of Dr. Ezra Hunt. We who are so casual today about epidemics, owe our relative immunity to scourges to dedicated men like Dr. Hunt.

Summarizing medical progress during the previous hundred years at the turn of this century, Sir William Osler stated, "Sanitary science, hygiene, or preventive medicine may claim to be one of the brightest spots in the history of the nineteenth century." Fifty years' time has strengthened Osler's assertion for it was during the nineteenth century that the modern public health movement developed—a movement which has produced great benefits in health and happiness of which we are heirs today. Dr. Ezra Mundy Hunt, one of the pioneers of this public health movement in the United States, has recently received increasing recognition for his role in this era of progress. In 1953 Dr. Hunt was included among the great pioneers of public health in this country by the American Public Health Association, being cited as an outstanding leader in health organization, administration, and the originator of our modern concepts of rural health services. A physician of many talents, Dr. Hunt contributed much to contemporary medical organization, epidemiology and communicable disease control, vital statistics and health education. A medical leader during his busy life, Hunt witnessed the period of empirical environmental sanitation during the mid-nineteenth century and the subsequent era of scientific communicable disease control through the application of bacteriology which dominated the scene at the turn of the century.

In our comparative security against epidemics today, it is difficult to realize the annual death and disease rolls, fifty years ago, from diseases now under control. Improved standards of health and lengthened life span are taken for granted by most Americans. These did not come about, however, without Herculean efforts on the part of the medical and allied professions. The relatively recent conquest of diseases spread by water, milk and foods and those transmitted by insects constitutes one of the technical triumphs of man. The four major keystones of this public health movement—sanitation, control of community infections, education in personal hygiene, and organization of medical services for the diagnosis and treatment of disease—have accomplished phenomenal results during the past

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*Read at the 29th Annual Meeting of the American Association of the History of Medicine, Duke University, Durham, N. C., April 21, 1956. The author acknowledges the assistance of Dr. E. Gurney Clark, Professor of Epidemiology, Columbia University School of Public Health.

Dr. Rogers is Assistant Professor of Preventive Medicine, Temple University School of Medicine, Philadelphia, Pa.

century. Ezra Hunt contributed in some measure to progress in each of these four fields. It is fitting now, over fifty years after his death, to review the life and work of this pioneer in public health.

Ezra Mundy Hunt was born in Metuchen, N. J., on January 4, 1830, the son of Rev. Holloway W. Hunt, a Presbyterian minister, and his wife Henrietta Mundy. After preparatory study at the Irving Institute at Tarrytown, N. Y., Ezra entered Princeton College, being graduated in 1849 with the Bachelor of Arts degree. After medical study with Dr. Abraham Coles of Newark, N. J., the celebrated physician-author, and Dr. Dayton Decker of Metuchen, Hunt received his M.D. degree from the College of Physicians and Surgeons in New York in 1852

Shortly after beginning medical practice at Metuchen in 1853, Dr. Hunt was appointed Lecturer on Materia Medica and Therapeutics in the Vermont Medical College at Woodstock. In the following year he was elected Professor of Chemistry, but declined the chair to resume his busy general practice at Metuchen. Here he remained until joining the Union Army in 1862 as assistant surgeon of the 29th New Jersey Infantry. After serving with this regiment, Hunt was placed in charge of the Calvert Street Hospital in Baltimore where he remained until the expiration of his term of military service.

In 1864, Dr. Hunt was elected the 71st President of The Medical Society of New Jersey, an organization of which he had become a prominent member. His presidential address concerned "Our Profession in its Three-Fold Relations, as a Science, a Business and an Art." Dr. Hunt continued to be an influential member of The Medical Society of New Jersey throughout his life. He served on numerous committees, contributed papers to its *Transactions,* and represented the Society at national meetings. A delegate to the American Medical Association in 1865, he subsequently represented New Jersey for several terms and became Secretary (1875) and Chairman (1877) of its Section on State Medicine and Public Hygiene (which had been founded in 1873). In 1880, Dr. Hunt was a Vice-President of the American Medical Association.

Having been instrumental in securing beneficial legislation in the interest of sanitation for New Jersey, Dr. Hunt was elected President of the State Sanitary Commission when this body was established by the Legislature in 1876. This Commission dealt chiefly with the prevention of cholera in that year, but its work led to the creation of a more substantial State Health Commission in 1874, of which Dr. Hunt served as president. In 1876 Dr. Hunt, then Secretary of the State Sanitary Association, went to Europe with Major John Shaw Billings. His mission was to observe sanitary progress and to inspect hospitals.

On October 7, 1876, Dr. Billings and Dr. Hunt sailed from Boston on the *S. S. Batavia.* The crossing was a stormy one, as Dr. Billings reported in letters to his wife:

> *October* 9. Dr. H., feeling better, came on deck this morning with his stovepipe hat on and an umbrella spread. The captain immediately stepped up to him and, with an air of great interest, inquired if he were going ashore. I think that Dr. Hunt will not appear in that rig again.

From London (October 22, 1876) Dr. Billings reported, "Have seen the sun once for a few minutes since I landed. This place is too big, it is about three miles to anywhere. Dr. H. sees more sights than I, but I see more men than he."

During two months in Europe the doctors visited medical facilities in the British Isles, France, Germany and Italy, and met such outstanding scientists as Thomas Huxley and Lord Lister. After returning home, Dr. Billings drew the plans for the Johns Hopkins Hospital and Dr. Hunt was instrumental in organizing the New Jersey State Board of Health in 1877. He was elected Secretary of this organization at its inception. He continued in this position for sixteen years, eventually relinquishing his medical practice to devote all his time to preparing its annual reports, superintending its bureau of vital sta-

tistics and teaching hygiene at the State Normal School at Trenton.

Ezra Mundy Hunt was a charter member of the American Public Health Association at its organization meeting held at Long Branch, N. J., on September 12, 1872. A devoted attendant at its annual meetings, he was the tenth president of the Association in 1882. From the first year he contributed valuable papers to the *Reports* of the Association, studies in epidemiology and rural health which are outstanding for their clarity and advanced ideas. Sixty-two entries appear for Dr. Hunt between 1859 and 1894 in the literature listed in the *Index Medicus*. His work covered medical practice, epidemiology and communicable disease control, environmental sanitation and occupational diseases, health organization and administration, vital statistics, personal hygiene, school health and health education. In addition, Dr. Hunt published considerable non-medical writing relating to his Civil War experiences, local historical and religious subjects.

Numerous distinctions came to Ezra Hunt during his lifetime. In addition to those already mentioned, he served as Alumni President of his class at Princeton (1859) and of the Association of Alumni of the College of Physicians and Surgeons (1872). His presidential address to the latter group, "The Lights and Shadows of Medical Science," emphasized the dignity and responsibilities of the medical calling and is still worth reading today. Princeton, in 1882, conferred an honorary Doctor of Science degree upon him, and in 1890 he received an honorary Doctorate of Laws from Lafayette College. In recognition of his outstanding work in communicable disease control, Dr. Hunt was made an honorary member of the Epidemiological Society of London in 1888—a distinction seldom granted to those outside of Britain. Dr. Hunt traveled to Europe several times later in life, as a delegate to the International Medical Congress at London in 1882 and at Copenhagen in 1884. Translations of several of his scientific articles were published in European medical journals.

In 1853 Ezra Hunt married Emma L. Ayres of Rahway; she died in 1867, and in 1870 he married Emma Reeve of Alloway, N. J. He had four children, two of whom became physicians—Ellsworth Eliot Hunt, who died in 1886, and Alonzo Clark Hunt who followed his father's interests in public health in New Jersey. A devout Presbyterian, Ezra Hunt served as an elder at the First Church of Metuchen for many years, and at the Fourth Church in Trenton where he spent the last ten years of his life. He died at Metuchen on July 1, 1894 and was buried in the family plot in the Presbyterian churchyard of his native town. In a memorial tribute Dr. William Elmer, President of The Medical Society of New Jersey and a close personal friend, cited Dr. Hunt's valuable influence upon the medical profession of his state and the esteem with which he was held by its citizens for his pioneer efforts on behalf of the public health.

Ezra Hunt's numerous publications, although largely outdated, provide examples of accurate observation and careful analysis of the general factors which determine the distribution of disease. In addition, his designs for rural health services are still worthy of study. Dr. Wilson G. Smillie has recently quoted from several of these papers in his texts on *Public Health Administration in the United States* (1947), and *Public Health: Its Promise for the Future* (1955).

Prefacing his chapter on "Epidemiology and Communicable Disease Control" in the latter volume, Dr. Smillie quotes Hunt's paper *The Need of Sanitary Organization in Villages and Rural Districts* (A.P.H.A. Reports 1872-73, New York, 1875).

> A great number of cases to observe is in some respects valuable, but confusion and difficulty of study sometimes arise from too great aggregation of disease under the extra artificial conditions of cities, hospitals, etc., and very much is to be learned from a few typical cases occurring under circumstances less complicated.
>
> There is often not so much to be learned by observing a very great number of cases as by an exhaustive searching into a few cases, all the facts of which are more within the grasp

Dr. Smillie comments that now, as in Dr. Hunt's day, good epidemiologic study need not be limited to large municipal and state health departments. In fact, there are many advantages which favor the rural health worker because his situation is less complex, human contacts less frequent and contribution factors more easily determined. A recent illustration is the volume *Epidemiology in Country Practice* (1939) by Dr. W. N. Pickles, rural health officer in Yorkshire, England.

Among the situations that precipitated early public health action, epidemic diseases occupied a prominent place. A physician who did his own epidemiology, Ezra Hunt made important contributions to this science by his methodical study of the cause and control of disease outbreaks in New Jersey. Numerous publications in this field include studies on the nature and distribution of cholera, influenza (the 1889 epidemic which predilected the elderly), malaria, smallpox, tuberculosis, typhoid, typhus, yellow fever, and the contagious diseases of domestic animals related to human illness.

IN A classic article *How to Study an Epidemic* (A.P.H.A. Reports 1877-1878, Boston, 1880), Dr. Hunt formulated seven requisites for investigating an epidemic. Although he had little information concerning specific etiologic agents which produce disease, his requisites were sound and penetrating. He indicated that the epidemiologist need not be on the spot where the epidemic prevails. It is a requisite in forming a clear, calculated and impartial judgment that objects be placed at a certain distance in order that they may be seen in their relative positions and importance. The following is a synopsis of Hunt's seven requisites for proper study of an epidemic:

1. A thorough understanding of the sense in which technical words are used. There may be a confusion of diagnostic terms, *e.g.*: "infectious," "contagious," "miasm," "malaria," "fomities," "zymotic," and the like.

2. Specifying the diagnostic character of the disease under investigation. One must be able to recognize the disease. Smallpox causes no confusion—yellow fever causes difficulty. It must be distinguished from other forms of fever.

3. Ascertained and expert methods for collecting facts. The technic should be comparable to the taking of testimony, and should follow legal standards of rules of evidence. "The facts and observations have to be studied inductively, deductively, analogically, numerically, and then grouped rightly for study."

4. Accurate analysis. "It must not make a verdict when possible sources of error have not been eliminated by sufficient massing of cases . . . The science or art is not in the facts but in logical reasoning thereon." The analysis must follow principles of evidence and methods of logic.

5. Careful collation and consideration of testimony as to former outbreaks and decorous consideration of the opinion of observers thereof.

6. Catechetical method of investigation. The first meaning of catechetical is instruction: asking intelligent questions, following the essential as distinct from the incidental, searching into every particular, for we sometimes discover truth where we least expect to find it.

7. Need for material support. One cannot study an epidemic without funds and personnel.

Dr. Smillie concludes: "Although three-fourths of a century have passed, a modern instructor in epidemiology might well utilize Hunt's seven requisites as the foundation of his teaching and investigation."

In a subsequent report *The Prevention of Epidemics,* read before the British Medical Association* in 1885, Ezra Hunt extended his concept of the epidemiologic method in light of further knowledge concerning the microbial origin of diseases. Outlining significant facts regarding the agent ("contagium vivum") environment ("surroundings"), and host (animal or human), he concluded:

> Last of all, comes the question of the limitation of diseases in their attempt to become epidemics, and after they have so become; the former being most valuable forethought, the latter being not unimportant afterthought. This limitation involves the study of the *natural history* of every communicable disease in all its minutiae, that we may know its times and seasons, the distance at which it can be propagated, the length of period of its communicability, the secretions or families most likely to convey it, the relation of breath and of air to it, and all other facts which are relative to its transmissibility . . .
>
> The most inspiring result of what we may call the modern departure in epidemiology is not so much the conclusiveness or completeness of facts in any one direction as the unmistakable indication of precision in the laws of communicable dis-

*British Medical Journal 1:534 (March 14) 1885.

eases, these being as accurate as those that obtain in nature, giving us the comfortable persuasion that they are ascertainable and classifiable, although for various reasons, difficult of ascertainment, but likely to yield to analytic and statistical methods, and to that tact of experience in observation which can be acquired but cannot be described.

Dr. Hunt's official papers document public health practice and environmental sanitation in New Jersey from 1877 to 1894. The Annual Reports of the State Department of Health for these years, compiled by him, include vital statistics, reports on communicable diseases, diseases of trades and occupation, problems of housing, sewage disposal, water pollution, charitable and penal institutions, nutrition and alcoholism, home and school health.

An early champion of health education in schools and colleges, Ezra Hunt organized the department of hygiene at the Trenton State Normal School in 1876 and served as its first instructor until his death eighteen years later. This institution, now the New Jersey State Teachers College at Trenton, is celebrating its Centennial this year. Evidence attesting the value of Dr. Hunt's teaching appears in the annual reports of the school during his instructorship. In 1886 we read the following:

> The regular lectures of Dr. E. M. Hunt, Secretary of the New Jersey State Board of Health, are prized as of utmost importance and value in imparting knowledge as to good habits, the care of health, the control of both body and mind, and the management of schoolroom atmosphere as to purity and temperature.
>
> In making the subject of hygiene, including all the term embraces, a prominent branch of Normal School education, the faculty have followed the wise judgment of our citizens as recognized and expressed by the enactment of the Legislature.

In the same year a copy of Hunt's book, *Principles of Hygiene for the School and Home*, was presented to each schoolteacher by the State Legislature. In addition to his lectures on hygiene, Dr. Hunt headed the department of physical education, served several years as secretary of the Athletic Association, and even played shortstop on the school's baseball team. Also in the cause of health education he contributed the medical information column to the New York "Independent" newspaper from 1881 to 1894.

The modern public health movement, slow in its inception but sure in its progress, depended much on men such as Ezra Mundy Hunt—versatile men who worked against huge obstacles to erect the foundations of our present edifice of public health. Sir William Osler, in his "Medicine in the Nineteenth Century," succinctly documents the contributions of these pioneers of public health:

> For countless generations the prophets and kings of humanity have desired to see the things which men have seen, and to hear the things which men have heard in the course of the wonderful nineteenth century. To the call of the watchers on the towers of progress there had been the one sad answer—the people sit in darkness and in the shadow of death. Politically, socially, and morally the race had improved, but for the unit, for the individual, there was little hope . . . In the fulness of time, long expected, long delayed, at last Science emptied upon him blessings which have made the century forever memorable; and which have followed each other with a rapidity so bewildering that we know not what next to expect. To us in the medical profession, who deal with this unit, and measure progress by the law of the greatest happiness to the greatest number, to us whose work is with the sick and suffering, the great boon of this wonderful century . . . is the fact that the leaves of the tree of Science have been for the healing of the nations.

Donnelly Memorial Hospitals

Trustees' Meetings

September 9, 1956

At its September 9 (1956) session, the Trustees of The Medical Society of New Jersey:

—Agreed to help implement the federal program for the medical care of the dependents of military personnel and designated Medical Service Administration as the Society's agent for this. A committee was named to work on the schedule and roster needed for the "Medicare Program." Named to this committee: Doctors McCall, Sica, Bowers, Ware and Borsher with Dr. McCall as chairman.

—Adopted the following resolution with respect to expert testimony in malpractice matters:

Whereas, The Medical Society of New Jersey has on occasion been criticized by some members of the legal profession because physicians were not obtainable to give medical testimony for claimants when the question of professional liability was involved, and

Whereas, this committee agrees that this condition may have occurred in a few instances although it does not recognize it as a common occurrence, therefore be it

Resolved that the Board of Trustees of The Medical Society of New Jersey be requested to study and evolve a plan so that upon request of the claimant's attorney and/or the court, one or more physicians who are members of The Medical Society of New Jersey and who are properly qualified, can be made available to examine the claimant in question and render an impartial opinion before the said court and jury.

—Referred to a special committee the problem of possible legislation which would permit suits against plaintiffs who maliciously brought complaints of unprofessional conduct against physicians.

—Tentatively approved a proposed State Health Department program for "tear-off" diet lists for doctors to give to patients, subject to prior review of proposed diets.

—Agreed to cooperate with the State Health Department on emergency medical service (civil defense) training activities.

—Authorized the Society's joining the American Association of Blood Banks as an affiliate member.

—Received report of Audit Committee finding our professional audit in good order, and approved of that report.

—Renominated the incumbents on the State Board of Medical Examiners for re-appointment thereto at the expiration of their terms.

—Approved a recommendation to re-adjust the salaries of full-time employees of the Society to keep such salaries on a par with those paid by the State Government in Trenton for comparable work.

—Discontinued the position of Assistant to the Executive Officer.

—Transferred to the House Reserve Account the sum of $7500 for necessary repairs and maintenance operations of our Society's building.

—Endorsed and agree to cooperate with the glaucoma detection program of the New Jersey Commission for the Blind.

October 7, 1956

At its October 7 session, the Board of Trustees:

—Retained the services of Robert M. Backes, of Trenton as Counsel for The Medical Society of New Jersey.

—Approved a proposed schedule of maximum fees developed in connection with the "Medicare" Program.

—Took action on proposed state legislation as indicated on page 561 of this JOURNAL.

—Authorized a meeting of a committee with a group from the New Jersey Bar Association to develop a plan for providing a panel of impartial medical and surgical experts from whom witnesses might be chosen in certain types of personal injury litigation. Any plan developed out of such session would be subject to approval at a subsequent meeting of the Board, also approval by our House of Delegates and, possibly, by judicial authorities.

—Sent a congratulatory telegram to Associate Justice William J. Brennan, Jr. of the United States Supreme Court.

—Authorized the President, President-Elect, Secretary and one alternate to attend

the A.M.A. Clinical Session in Seattle in November, with expenses paid.

—Approved of the following recommendations of the special Industrial Health Committee:

To provide a forum for comment on the common and reciprocal problems of industrial health, it is *recommended* that the various committee members of the Special Committee on Industrial Health offer their services for an address or question and answer period at various meetings of the various county societies.

It is *recommended* that the Special Committee on Industrial Health plan for participation in the Annual Meeting, through a scientific exhibit.

It is *recommended* that the committee seriously consider the possibility of conferences of general practitioners, industrial physicians, and management representatives for exploration and orientation in matters of mutual interest.

—To urge the development of courses in occupational medicine in existing or contemplated medical schools in New Jersey. Because of the significant diversity and concentration of industry in New Jersey, an exceptional opportunity is available for leadership and constructive action in educational activity directed toward the advancement and enhancement of legitimate and ethical medicine in the industrial environment.

—Received through the Welfare Committee the following two recommendations from the Special Committee on *Mental Health*. The Board of Trustees voted that no action on either recommendation was necessary:

That the Chairman of the Subcommittee on Public Health and the President of the Medical Society be urged to disseminate information to the component medical societies to the effect that psychiatrists are available as speakers on psychiatric subjects and psychiatric problems that might be of interest to medical society members.

That the Medical Society reiterate its stand that the practice of medicine be reserved to licensed physicians.

Two other recommendations — legislation for licensing psychologists and program of psychiatric services in general hospitals — were referred back to the special committee for further study and clarification.

A fifth recommendation pertaining to marriage counseling was received as a progress report only.

The subcommittee, at its meeting, had also adopted a recommendation urging legislation that tranquilizing drugs be included in the category requiring a physician's prescription. However, it was subsequently learned that tranquilizing drugs are under federal legislation. They are known as "federal legend drugs" and carry labels imprinted with "Federal law prohibits dispensing without a prescription." Therefore, the recommendation was not presented.

—The Society's attitude towards "lay" health organizations was discussed. For some years the policy has been that the Society will not endorse any organization in which it does not have a vote in shaping policy. The Welfare Committee has proposed the following as a less negative way of expressing this doctrine. The Trustees adopted the following recommendation after inserting the phrase that consultation does not imply endorsement:

We recommend to all lay groups interested in community health that requests be made of The Medical Society of New Jersey for the appointment of liaison personnel to their organizations so that medical viewpoints will be properly considered in the planning stages of their committee activity, thus by preconsultation hasty acceptance of a worthy project will not be necessary; it being further understood that consultation in no way implies endorsement.

It was directed that the presidents of the appropriate organizations be so notified.

—The Editors of this JOURNAL and of the *News-Letter* are asked to remind doctors that Salk vaccine is now available for the care of all patients, whether indigent, medically indigent, or private, and stating it is the physician's responsibility to pick up the vaccine now while it is available.

—Adopted the following Public Relations platform:

1. That this year primary emphasis be placed upon the fact that every individual doctor is an essential factor in the achievement of good public relations for medicine. Whatever the individual doctor says and does will largely determine his patient's impression of the worth of the entire profession. Throughout the year constant stress will be placed upon this concept.

2. That a uniform indoctrination program be prepared under the direction of the subcommittee for utilization in all the component county societies.

3. As a means of assisting the members in better understanding his relationship to organized medicine, that The Medical Society of New Jersey purchase a copy of the "Doubting Doctor," a film produced by the American Medical Association, and make it available for presentation before county medical societies.

4. That every county medical society compile a detailed attendance record covering all regular meetings of its society; and that a copy of it be recorded locally and be annually submitted to the

Executive Offices to assist the state society officers in making dependable appointments to the committees of The Medical Society of New Jersey.

5. In view of the fact that the New Jersey Press Association, through its Board of Directors, has recently recorded its willingness to "extend to The Medical Society of New Jersey any help the Society might require if the Society is undertaking a new program to improve medico-press relations,"—that a joint committee on press relations be formed, to be made up of equal membership from the Subcommittee on Public Relations and the New Jersey Press Association. It will be the function of this joint committee to work out a "code of cooperation," to be submitted for adoption by the parent organizations.

Legislative Index

Following is the final action taken on certain legislation by the Trustees at their October 7 (1956) session. These matters had been considered by the Subcommittee on Legislation and by the Welfare Committee prior to submission to the Board. Action taken by Board is italicized.

A-3. To require licensing of practical nurses. *Approval re-affirmed.*

A-22 and also A-300. To permit an injured employee to select the physician he wishes to treat him under Workmen's Compensation. *No action.*

A-22 originally was approved in support of the principle of free choice of physician by the patient. However, since the patient (employee) is not the individual responsible for the payment of the physician's fee, the free choice might more properly be the right of the responsible contracting agent (employer). Also approval of such measure could be construed as supporting the idea that licensed chiropractors are regarded by the Medical Society as acceptable to render treatment. Therefore, the subcommittee decided to withdraw its earlier approval of A-22.

A-284—To permit county prosecutors to apply for commitment of an individual to a mental institution. *Approved.*

A-286—To authorize specialized treatment at the Diagnostic Center in certain cases of lewdness or indecent exposure. *No action.*

A-317—To make any person who sells or furnishes to a minor under 16 years of age, other than the holder of a valid bow and arrow hunting license, any pointed or metal-tipped arrow, except those designed for target use, a disorderly person. *No action.*

A-321—To permit counties to establish facilities for the treatment of alcoholics, and to permit commitments in certain cases by a superior or county court judge or a municipal magistrate. *No action.*

A-337—To make those under the influence of a narcotic not lawfully prescribed or administered disorderly persons. *No action.*

A-414—Requires physicians, dentists, and pharmacists prescribing or compounding a prescription to be administered to a child under age four, to include in such prescription the name and dosage and directions for use; prescribes penalties from $100 to $200 for the first offense and of at least $200 for subsequent offenses. *Disapproved as written.* The Society recognizes that the bill has a laudable intent. It opposes it as an unsatisfactory means for the end which it seeks to accomplish.

A-414 was originally "approved in principle; however, the opinion prevailed that this is an unsatisfactory means for the end sought." The subcommittee felt the casual reader seeing "approved in principle" would conclude that the Society officially approved the bill, whereas actually it disapproves of it as an incompetent measure. The subcommittee also discussed alternative methods of effecting the purpose of the bill without recourse to legislation, possibly by a general pharmaceutical regulation. Therefore, the subcommittee withdrew its earlier position on A-414.

A-36—To exempt holders of medical licenses from the provisions of the act requiring licensing of bio-analytical laboratories and technicians. *Active support.*

A-461—To forbid optometry practice under lease from an unregistered optometrist or physician or in an office not exclusively devoted to optometry. *No action.*

A-472—To provide for the licensing and regulation of private mental hospitals and to add to the membership of the hospital licensing board. *No action.*

A-504—To extend until December 31, 1959 the time within which certain New Jersey residents who studied medicine in foreign schools may be eligible for state licensing. *Disapproved.*

A-524—To permit chiropodists to perform bone resections and treat fractures and dislocations of the foot. *Disapproved.*

A-525—To permit boards of education to employ chiropodists. *Disapproved.*

A-547—To eliminate the provision fixing the qualifications for taking examinations to practice medicine and surgery that the applicant must have studied at least one foreign language. *Approved.*

AJR-14—To create an 8 member Charitable and Philanthropic Fund Raising Study Commission to

study and investigate such fund raising activities. *Approved.*

ACR-42—To create a Commission on Mental Health to study the procedures for admission, confinement, care, release, and rehabilitation, of mentally ill and mentally defective persons. *Approved.*

S-127—To require employers under Workmen's Compensation to designate and post a panel of physicians from among whom the employee may choose to be treated. *No action.*

S-146—To permit commitment to the Diagnostic Center of persons convicted of assault with intent to commit sexual offenses. *No action.*

S-209—To provide that hypertension, heart disease, and tuberculosis incurred by firemen shall be deemed to be occupational diseases. *Disapproved.*

S-218—To provide for compensation for the examining physician in drunken driving cases. *No action.*

S-234—To permit civil suits with punitive damages against persons who falsely and maliciously make complaints against members of professions regulated by a county or other public body. This is now law. See page 563.

S-240—To require that an injured employee be furnished reports of the treating doctor or hospital by the employer or workmen's compensation carrier. *Disapproved.*

S-275—To permit hospital service plans to cover certain dental services. *No action.*

S-276—To permit hospital service plans to cover convalescent care in registered nursing homes. *No action.*

SJR-11—To create an Atomic Energy Study Commission. *Approved.*

Safety "Shots" in the Office

We physicians insist that children be brought to the office at regular intervals for routine examinations and for inoculations. Too many of us are satisfied to let it go at that. We are not giving parents their full money's worth when we forget the "safety" shots, which may save the family future heartaches and expense. All that is needed is to make this a part of our office routine.

Accidents cause more deaths among children than do diseases. The highest accident rate is among preschool children, those who spend most of their time at home under parental supervision; and at least 90 per cent of the accidents are preventable. Parents should be told about the possibilities of accidents and how to avoid them, the safety "shots" that each parent can take.

The American Academy of Pediatrics and its state chapters have made this one of their major projects. Selling it to the parents may be easier than selling it to the physicians. A list of home hazards should occupy a prominent place in the doctor's office. Such a list is available in De Sanctis and Varga's *Handbook of Pediatric Medical Emergencies.** It is well to emphasize a few of these facts. First, the newborn baby needs absolute protection. He soon may roll off the table when mother answers the doorbell or bury his nose in a soft mattress, or run into trouble when left alone for a moment in the tub. Then as he grows into the wandering and climbing age, the mother must be reminded of the dangers from protruding pot handles on the stove, of empty light sockets, of heavy lamps that can be pulled over, and of poisons within climbing reach in the medicine cabinet, including the open bottle of aspirin tablets. Remind parents to keep knives and scissors out of reach, and firearms locked up. These are so obvious that we may forget to mention them to the new mother; but if we want to give her family the best in preventive care, we will keep reminding her of the many accident possibilities that lurk in an otherwise well regulated household. These are the safety "shots" she so sorely needs.

WALTER B. STEWART, M.D.

This Column is sponsored by New Jersey Chapter of The American Academy of Pediatrics.

*Published by C. V. Mosby Company, St. Louis, Mo.

Malicious Complaints Against Professional Persons

At its October 7, 1956 session your Board of Trustees adopted a resolution calling on THE JOURNAL to acquaint members with the provisions of chapter 122, Laws of 1956. The law affords a professional person protection against malicious complaints that lead to professional embarrassment.

The purpose of this statute is to afford protection to members of the professions against false and malicious charges of unprofessional conduct. Where the State regulates a profession and requires qualifications for the practice of the profession, it will afford this protection to the members of the profession.

CHAPTER 122

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey*:

1. Any person who falsely and maliciously and without probable cause makes a complaint, orally or in writing, of unprofessional conduct against a member of any profession requiring a license or other authority to practice such profession, to any court or to any ethics and grievance committee, or to any board or other public body authorized to and having the right to hear such complaint and to act thereon or to recommend action thereon and to take or recommend the taking of disciplinary action against the person complained of, such as disbarment or suspension in the case of an attorney-at-law, or the revocation or suspension of a license of other professional persons, shall be liable for any and all damages suffered and sustained by the member of a profession so complained of, to be recovered in a civil action in the nature of an action at law for malicious prosecution. In any such action, exemplary or punitive damages may be awarded.

2. Every such action shall be deemed to be for an injury to the person caused by the wrongful act of the person causing such injury and shall be commenced within two years next after the cause of any such action shall have accrued.

Having been signed by Governor Meyner, this statute is now in effect.

The Pathologist is Not the Tissue Committee*

The Joint Commission on Accreditation of Hospitals is a remarkable bird—a phoenix . . . which, having arisen from the warm and fertile ashes of many medical organizations, has in turn brought forth other equally remarkable creatures. One of these is a new concept of the old idea of the Tissue Committee. Every hospital has to have one to be eligible for approval.

The old concept of the "Normal Tissue Committee" has been tried and found wanting. Normal tissue removal is sometimes justified; on the other hand, surgical removal of diseased tissue is not always necessary. With the scientific attitude toward modern staff committee work, the "Unjustified Surgery Committee" came into being. Here all surgical cases are scrutinized whether tissue is removed or not. Pre- and postoperative diagnoses are as important as the separation of tissue by the surgeon's knife. Good medicine is the pass-word.

The newer concept is the professional audit. Although its eye is still on the surgeon, the Surgical Audit Committee is but one of many self-evaluating committees of the medical staff. With a medical staff's truer scientific attitude toward the problem of self-evaluation which faces it, the work in all services, including pathology, is now subject to staff evaluation. It is unscientific to rate a hospital by the work of the surgeons alone.

The Joint Commission insists that the committee be active, and not just a list of names on paper, *i.e.*, a "tissue paper committee." The viewpoint of all audit committees must be broad and clinical.

The pathologist is usually a member of the Surgical Audit Committee, but the American College of Surgeons emphasizes that *he should not be the chairman*. Further, the staffs of more and more hospitals are writing into the hospital by-laws that the pathologist should serve as a non-voting consultant.

Justification of an operation can rarely be made through a microscope.

The pathologist's report is the beginning, not the end, of surgical evaluation, the Regents of the American College of Surgery reported in Chicago in October, 1953 (The Modern Hospital, November, 1953).

Pathologists of New Jersey pledge their cooperation with the other physicians on hospital staffs in meeting the self-evaluation program required by the Joint Commission on Accreditation of Hospitals.

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*By New Jersey Society of Clinical Pathologists (Adapted from material released by the Texas Society of Pathologists).

Can You Pass this Hospital Quiz?

What does the doctor know of the size and extent of America's hospital empire? Here are some questions. The answers are based on an American Hospital Association release dated August 1, 1956.

Try this out, doctor. Check your answer. Then compare with the right answers on page 572.

1. How many different patients do our hospitals (nationwide) care for in a year?

(a) 5 million
(b) 10 million
(c) 15 million
(d) 20 million
(e) 25 million

2. How many babies are born in our hospitals (nationwide) every year?

(a) 1½ million
(b) 2½ million
(c) 3½ million
(d) 5 million
(e) 10 million

3. How much money do hospitals throughout the country spend in one year?

(a) 10 million dollars
(b) 100 million dollars
(c) a billion dollars
(d) 2½ billion dollars
(e) 5 billion dollars

4. In the average nonprofit *general* hospital, the per diem cost for the care of a patient, not counting physician's services, approximates:

(a) $5 a day
(b) $15 a day
(c) $25 a day
(d) $37 a day
(e) $45 a day

5. In the average *state* hospital (for mental patients) the per diem approximates:

(a) $ 3.50 a day
(b) $ 8.00 a day
(c) $11.00 a day
(d) $15.00 a day
(e) $20.00 a day

6. Of *all* hospital beds, what percentage are in mental hospitals?

(a) 20 per cent
(b) 35 per cent
(c) 43 per cent
(d) 67 per cent
(e) 78 per cent

7. How many hospital beds are there in the United States?

(a) ¾ million
(b) 1½ million
(c) 2½ million
(d) 3½ million
(e) 4½ million

8. The typical nonprofit general hospital has income from contributions, patients, grants and endowments. Income from patients (directly and *via* insurance reimbursement) approximates what percentage of hospital income?

(a) 51 per cent
(b) 61 per cent
(c) 71 per cent
(d) 81 per cent
(e) 91 per cent

9. Hospitals pay out for food, salaries, repair, supplies, interest and so on. What percentage of the hospitals' disbursements go to meet the payroll?

(a) 54 per cent
(b) 64 per cent
(c) 74 per cent
(d) 79 per cent
(e) 85 per cent

10. How many professional nurses (don't include pupils and practical nurses) are on the payrolls of the hospitals of this country?

(a) 250 thousand
(b) 400 thousand
(c) 500 thousand
(d) 600 thousand
(e) 700 thousand

11. What is the average patient stay in a "short-term" general hospital (*i.e.* excluding patients in tuberculosis sanitaria, mental hospitals and institutions for chronically ill)?

(a) 6 days
(b) 8 days
(c) 10 days
(d) 12 days
(e) 14 days

12. The total assets of American hospitals amount to

(a) 1 billion dollars
(b) 6 billion dollars
(c) 12 billion dollars
(d) 20 billion dollars
(e) 35 billion dollars

13. Suppose we define a "small hospital" as one which has fewer than 100 beds. Of all hospitals in the U.S.A. what proportion are small hospitals?

(a) 15 per cent
(b) 30 per cent
(c) 40 per cent
(d) 50 per cent
(e) 60 per cent

14. Throughout the country, how many patients are in hospitals today?

(a) ¾ million
(b) 1¼ million
(c) 2¼ million
(d) 3¼ million
(e) 4¼ million

Obituaries • • •

DR. ARON A. BENGELSDORF

Dr. Aron A. Bengelsdorf died on September 13 while seeing patients at his office. Born in Poland in 1891, Dr. Bengelsdorf attended the medical school of the University of Koenigsberg, from which he received an M.D. degree in 1914. He was graduated on the eve of World War I and became a captain in the medical corps of the Czarist army. Three years after the armistice he came to the United States and settled in Newark. Dr. Bengelsdorf built a large family practice, but after 1930 became increasingly interested in endocrinology and metabolic disturbances. He was affiliated with the Presbyterian, Beth Israel and St. Michael's Hospitals all in Newark. Dr. Bengelsdorf was also a lecturer on nutrition at New York Postgraduate Hospital. He was active in the Essex County Medical Society.

DR. WILLIAM C. CALVERT

At the untimely age of 53, death suddenly came to Dr. William C. Calvert on September 29. Born in New York in 1903, Dr. Calvert earned his B.S. at Dartmouth, and, in 1929, his M.D. from the New York Medical College. A general practitioner, Dr. Calvert was much interested in industrial medicine and served for some years as one of the plant physicians for the Edison industries. Since 1946 he was one of the senior physicians to the West Orange school system. His interest in industrial medicine extended to the whole field of rehabilitation, and he was affiliated with the Kessler Institute.

Dr. Calvert was also associated with the East Orange General Hospital, Orange Memorial Hospital and the Montclair Community Hospital. He saw foreign service with the Army in World War II. He was active in the American Society of Industrial Physicians and in the Essex County Medical Society.

DR. JACOB J. GREENGRASS

While quietly sitting at home, reading in a chair, death came to Dr. Jacob J. Greengrass. This occurred on October 7. Born in New York in 1887, he was graduated in 1911 from the medical school of the University of Maryland. He came to Paterson General Hospital for his internship in 1911 and 1912. After 5 years of neighborhood practice in Paterson, he sought and obtained a commission in the medical corps of the U. S. Army. On being mustered out, he became interested in dermatology, devoting more and more of his time to that specialty. He became chief of the dermatology service at the Barnert Memorial Hospital. Dr. Greengrass was also active in civic affairs and was vice-president of the Broadway (Paterson) Bank and Trust Company at the time of his death.

DR. GEORGE M. LEVITAS

An emeritus member of the Bergen County Medical Society, Dr. George M. Levitas died on September 16 at the age of 74. A native of Estonia, Dr. Levitas came to the United States at the age of 9. In 1904 he received his M.D. degree at the Long Island College Hospital. He then moved to Westwood Borough, and served the people of that community—especially its children—for almost half a century. He did graduate work in pediatrics and was chief of that specialty at the Hackensack Hospital. He served as president of the Bergen County Medical Society, and was a member of the Board of Governors at Bergen Pines. He was an F.A.C.P. and was a founder and first president of the local chapter of the Red Cross. He served as president of Rotary in Westwood and as president of the Bergen County YMHA. He established some years ago a college student loan fund to aid financially needy students. The *Bergen Evening Record*, in an editorial on his death, characterized Dr. Levitas as "a modest man who rolled up his sleeves to make the world a better place, a distinguished practitioner in the art and discipline of being a responsible member of the human race."

DR. IRVING A. MEEKER

One of Essex County's senior physicians died on September 15 with the death that day of Dr. Irving Avard Meeker. Born in Mercer County in 1873, his family brought him to west Essex in 1880. In 1898 he received his M.D. degree from New York Medical College. In the following year, he opened his office in Upper Montclair and he continued to serve the people of that town from 1899 until his retirement in 1945. He was an emeritus member of the Essex County Medical Society and was, for years, active in the affairs of the Union Congregational Church in Montclair.

Announcements • • •

Fellowships in Cardiology

The Department of Cardiology of St. Michael's Hospital, Newark, will have available, beginning July 1, 1957, one clinical trainee Fellowship and one research trainee Fellowship in Cardiology. Both Fellowships are recognized by the National Heart Institute and are credited toward one year of residency in Internal Medicine. Applicants must have completed at least two years of an approved residency in internal medicine. United States citizenship is required.

If interested communicate immediately with N. A. Antonius, M.D., director, Department of Cardiology, St. Michael's Hospital, 305 High St., Newark, N. J.

Industrial Medicine Program

At 4:30 p.m. on December 6, a special program on medical effects of radiation will be held at the Roosevelt Hotel in New York City. For full program, write to Dr. Harry Tebrock, Society of Industrial Medicine, 1740 Broadway, New York 19, N. Y.

Radiologic Safety

A two-week full-time course in Radiologic Safety will be given from January 7 to 18, 1957, by the New York Univesity Post-Graduate Medical School, in cooperation with the United States Atomic Energy Commission.

The course is designed for physicians, engineers, and individuals in research laboratories.

For the convenience of those who cannot take the course full-time, it will be repeated on a part-time basis from January 30 to May 22, 1957. There will also be an optional two-week laboratory session from January 21 to February 1.

For further information write to the Dean, Post-Graduate Medical School, 550 First Avenue, New York 16, N. Y.

Prize Contest for Medical Students

Cardiology, mental disease, and eye disorders are the topics for the 1957 Schering Award Contest medical students are invited to submit papers on.

1. Incidence of cardiovascular diseases by age group.
2. Recent trends in corticosteroid therapy for ocular disorders.
3. Recent advances in the biochemical aspects and treatment of mental disease.

Literature and entry forms are being distributed in medical schools. Students interested in participating should submit entry forms by January 1, 1957. The Schering Corporation is in Bloomfield, N. J.

During the past several years a growing number of Schering Award winning papers have been published in professional journals. The calibre of work by many participating students has been so high that they will undoubtedly contribute significantly to the professional literature during their medical careers.

Calling All Blockley Alumni

The annual dinner of the ex-residents of the Philadelphia General Hospital will be held at 7 p.m. on December 4 at the Penn-Sherwood Hotel in Philadelphia.

Medico-Legal Society Now Forming

All readers of this JOURNAL interested in the legal aspects of medicine (testimony, evaluation, causes of death, malpractice and so on) are invited to come to a meeting in Newark on Wednesday evening, November 21 at 8:30 p.m. to help form a New Jersey Medico-Legal Society. Come to the auditorium of the law school at 53 Washington Street, Newark.

Glaucoma Lecture

The Schoenberg Memorial program of the New York Society for Clinical Ophthalmology will be held at 8:15 p.m., Monday, December 10, 1956, at The New York Academy of Medicine.

Irving H. Leopold, M.D., the University of Pennsylvania, will speak on "Recent Advances in the Medical Therapy of Glaucoma." Dr. Hans Goldman of the University of Berne, Switzerland, will discuss, "The Problem of Glaucoma in Myopia." All physicians will be welcome.

Polish Medical Journal

A slick-paper, beautifully illustrated *Bulletin of Polish Medicine and Science* is now available on a subscription basis. Written in English, this new magazine focuses on the proud medical history of Poland, includes abstracts of the current literature and carries original articles. For more details write to Bulletin of Polish Medicine at 2424 North Kedzie Blvd., Chicago 47, Illinois. *Zycze powodzenia!*

Salk Vaccine Available

At its October 7 (1956) session, the Trustees instructed THE JOURNAL to make the following announcement with reference to Salk vaccine:

That The Medical Society publish an article in THE JOURNAL that the vaccine is now available for the care of all patients, whether indigent, medically indigent, or private, and stating it is the physicians' responsibility to pick up the vaccine now while it is available.

Want to Go to Hawaii?

From February 4 to 6, 1957, the American Academy of Allergy will hold a session in Los Angeles. Then from February 7 to 19 there will be a scientific program in Honolulu. Special arrangements have been made for low-rate transportation. For details write to the American Academy of Allergy, 208 E. Wisconsin Avenue, Milwaukee 2, Wis.

Proctology Award

A $100 award is announced for the best previously unpublished contribution on proctology or allied subjects. The sponsor is the International Academy of Proctology. Entries are limited to 5000 words and must be submitted in five legible copies on or before February 1, 1957. All entries should be sent to the International Academy of Proctology, 147-41 Sanford Avenue, Flushing, New York.

Obstetrics for General Practitioners

Co-sponsored by the Maternal and Infant Welfare Committee of The Medical Society of New Jersey, is a course given under the auspices of the New Jersey Department of Health at the Martland Medical Center in Newark on obstetrics for the general practitioner. The small fee of $25 is made possible by a grant by the State Department of Health. The lectures are held on Wednesdays from 4 to 6 p.m. and include a list of outstanding and well-known obstetricians. All aspects of obstetrics will be covered. The first meeting is November 21 and the last is April 3, 1957. For registration or more details write to Seton Hall College of Medicine, Jersey City Medical Center, Jersey City, New Jersey.

County Society Reports . . .

Camden

The regular monthly meeting of the *Camden County Medical Society* was held October 2 in the meeting rooms of the Society, with Dr. George P. Meyer, President, presiding.

Dr. John M. Collier was introduced to the Society after taking the membership oath and signing the register.

The President presented Dr. Charles H. Jackson with his 50 year certificate. Dr. Jackson's and Dr. A. B. Davis' names were added to the 50 year plaque on the wall of our meeting room.

Dr. Elmer Grimes introduced a panel composed of Dr. John Kimmich (Campbell Soup Company), Drs. F. Curtis Dohan and Walter G. Vernon (RCA), Dr. Cletus Schwegmann, Assistant Professor of Surgery, and Dr. Henry Moss, Instructor in Surgery, University of Pennsylvania. Industrial medicine, with emphasis on surgical convalescence was discussed. Dr. Vernon informed the members that they are going to institute a research in which 25,000 workers are to be covered.

The membership moved that the Trustees be empowered to dispose of the present property and purchase a new medical society home.

EUGENE H. KAIN, M.D.
Reporter

Gloucester

The *Gloucester County Medical Society* opened its 1956-57 program on September 20 with a meeting at the Research and Development Center of the Socony-Mobil Oil Company plant at Paulsboro. A tour by the doctors showed us some of the facets in basic petroleum research, and included the electron microscope, the electronic computer, pilot plant operation, and testing engines. The tour was followed by an enlightening discussion given by Dr. Chester L. Samuelson, plant physician and president of the Gloucester County Medical Society, and the plant safety directors.

At its business session, the Society approved the establishment of a rheumatic fever clinic under the auspices of The Gloucester County Heart Association. The Society passed a resolution to censure any member who does not abide by the resolution passed by the Society in January 1956. This refers to the participation of Society members in special free clinics for administration of Salk poliomyelitis vaccine.

Following the meeting the members enjoyed refreshments served in the cafeteria of the Socony-Mobil Research and Development Center.

R.. D. LOVELACE, M.D.
Reporter

Passaic

The regular monthly meeting of the *Passaic County Medical Society* was an installation dinner, introducing Dr. Abraham Shulman, the new president. The meeting was held in the Grand Ballroom of the Alexander Hamilton Hotel on September 19, 1956, and attended by 200 members and guests. The Reverend George H. Talbott gave the invocation. Dr. S. A. Levinsohn was toastmaster. After the dinner, a short business session was held at which the following were elected to active membership: Dr. Paul F. Crutchlow of Paterson, Dr. Hanfred R. Seela of Ridgewood, Dr. Almerindo G. Portfolio of Oakland. Elected to associate membership were: Dr. James A. Reilly of Preakness and Dr. Igor Sinchugov of Passaic.

Dr. Joseph R. Jehl, the retiring president, was presented with a gavel in appreciation of his services during the past year. Dr. Abraham Shulman, the newly elected president, was introduced. He said that the theme to govern his term of office would be "Maintenance of Good Public Relations."

The other officers installed included Dr. Samuel C. Yachnin, first vice-president; Dr. Theodore K. Graham, second vice-president; Dr. Joseph F. Moriarty, secretary; Dr. Frank B. Vanderbeek, treasurer; Dr. David B. Levine, reporter; and Dr. John A. Ianacone, editor.

Guests at the dinner included Dr. Lewis C. Fritts, President, and Mr. Richard I. Nevin, Executive Officer, of The Medical Society of New Jersey, both of whom addressed the group; also Mayor Edward J. O'Byrne of Paterson, Dr. John W. Surgent, Mayor of Clifton, Mayor Paul G. DeMuro of Passaic, Mr. Harvey S. Schoenfeld, Director of the Barnert Hospital; of Bergen County Medical Society guests were: Dr. William T. Knight, President, Dr. Leo Fitzpatrick, First Vice-President, and Mr. Allen W. Fincke, Executive Secretary; the emeritus members of the Passaic County Medical Society included Drs. Louis Lipton, Charles R. Mitchell, Charles J. Murn, William P. Thorne.

Dr. Levinsohn then introduced the principal speaker of the evening, David B. Allman, M.D., President-elect of the American Medical Association. Dr. Allman's topic was "The A.M.A., the Doctor and the Public."

DAVID B. LEVINE, M.D.
Reporter

Salem

Dr. Isadore Lipkin presided over his first meeting of the *Salem County Medical Society* since his election; the occasion was the first regular meeting of the society on September 21, 1956, at the Du Pont-Penns Grove Country Club. Dr. John S. Madara reported on the September 16 meeting of the Subcommittee on Legislation of the State Welfare Committee. Dr. Charles Gilpatrick and Dr. C. B. Norton asked for expressions of opinion from the society on matters awaiting discussion by the Subcommittees on Medical Practice and on Maternal and Child Health. Dr. Loring E. Sylvester was elected to membership. Dr. George Nitshe reported that all members of the society whom he had surveyed wished to join the Hospital Service Plan of New Jersey through the society, and he was thereupon elected treasurer and instructed to make the necessary arrangements. Dr. Lipkin announced that Dr. Albert Sungenis of Pennsville would communicate with the doctors in the county for contributions to the United Fund.

Dr. W. Garrett Hume introduced the speaker, Dr. Lewis Flynn, head of the Department of Medicine at Delaware Hospital. Dr. Flynn spoke on Office Treatment of Diabetes.

W. L. SPROUT, M.D.,
Reporter

N. J. Orthopedic Society

The Hunterdon Medical Center in Flemington was the site of the 1956 Annual Meeting of the *New Jersey Orthopedic Society*. Dr. Bernard Halbstein of Long Branch was elected president of the organization and Dr. Harold Hansen of South Orange was designated president-elect. Named as treasurer was Dr. John Naame of Atlantic City. The new secretary will be Dr. Otto Lehmann of Long Branch.

ARTHUR S. THURM, M.D.

Woman's Auxiliary • • •

Essex

The Reorganization Board Meeting of the *Woman's Auxiliary to the Essex County Medical Society* was held on June 12, 1956. Forty members attended.

Mrs. Michael Pierce, Chairman of Booths, and her co-chairman, Mrs. Carlyle W. Schumacher, has announced the completion of their project to bring up-to-date the files of the Tuberculosis League.

The United Appeals-Red Cross "Kickoff Luncheon" was held October 3. The following members of the Woman's Auxiliary acted as hostesses: Mrs. Irving Borsher, Mrs. Anthony Caggiano, Mrs. Philip D'Ambola, Mrs. Harry DiGiacomo, Mrs. Don A. Epler, Mrs. Jesse Glazier, Mrs. William Miningham, Jr., Mrs. V. Francis Pakonis, Mrs. Edwin Seifert, and Mrs. H. Roy Van Ness. Participation in this event by the Auxiliary members was made possible through the efforts of Mrs. Asher Yaguda.

The Community Health Committee met at the home of Mrs. Lloyd Felmly, Jr., co-chairman, to discuss the proposed outline of their program for the coming year. The committee is under the chairmanship of Mrs. Asher Yaguda.

A combined dinner meeting of the Essex County Medical Society and the Woman's Auxiliary was held at the Hotel Suburban on October 10. Guest speaker was Dr. David B. Allman, of Atlantic City, President-elect of the American Medical Association.

Posters and flags were used to emphasize the theme "United Nations" at the Annual Fall Luncheon of the Woman's Auxiliary, held on October 22. The President, Mrs. Harry E. DiGiacomo, presided at the meeting. The following were guests of honor: Dr. Marcus Greifinger, President of the Essex County Medical Society, Dr. Edward Gullord, President-elect of the Essex County Medical Society, Dr. Ronald F. Buchan, President of the Academy of Medicine of New Jersey, Mrs. Bertram J. L. Sauerbrunn, President of the Woman's Auxiliary to The Medical Society of New Jersey, and Mrs. John C. Voss, President-elect of the Woman's Auxiliary to The Medical Society of New Jersey. Mrs. Robert J. Citrino and Mrs. Harry Taff were in charge of arrangements and reservations for the luncheon.

MRS. EDWIN SEIFERT,
Chairman, Press & Publicity

Book Reviews • • •

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

Bone and Bones: Fundamentals of Bone Biology. By Joseph P. Weinmann, M.D. and Harry Sicher, M.D. 2nd ed. Pp. 508. St. Louis, Mosby, 1955. ($13.75)

The first part of this book provides an excellent introduction to the normal structure, development and growth of bone. Photomicrographs clarify these complex processes. The material relating to the teeth and jaws will be of special interest to dentists.

The second portion of the book is devoted to the pathology of the bones. Developmental disturbances and adaptational abnormalities of the skeleton are included. Chapters on how vitamins, hormones and minerals affect bones, as well as the discussion of the healing of bones are well organized. An extensive bibliography is appended.

The vastness of the subject precludes the possibility of its being presented adequately in one volume. The sections on necrosis and inflammation of bones and bone tumors suffer for this reason.

Those who read this work will have a broader perspective and increased respect for the important relationship which the bones bear to the other organs of the body. The authors' concept of bones as "living organs" rather than relatively fixed, inert supporting structures is an important contribution toward our better understanding of the biology of the skeleton.

HERBERT M. SIMONSON, M.D.

Pathology for the Surgeon. By William Boyd, M.D. Ed. 7. Pp. 737. Philadelphia, Saunders, 1955. ($12.50)

This work spans the 8 years since the last edition and appears thirty years following its first publication. At that time it was entitled "Surgical Pathology." The new title as interpreted by the author represents a complete rewriting not merely a revision of an old book. The text is for the surgeon and the graduate student rather than for the pathologist. Greater emphasis is placed on clinical aspects of disease. To present this as accurately as possible, Dr. Boyd has enlisted the aid of 9 colleagues at the Vancouver General Hospital who have edited the sections relating to their specialties.

The chapter on general pathology of tumors is outstanding. In thirty pages the author has been able to condense the most advanced thoughts on the etiology and biology of tumors. Treatment is also discussed very simply.

The book is written in a flowing style sprinkled with many homey quotations and personal remarks. These are strategically placed and illuminate the discussion. The writing is typical of this genial author, and, if anything, has improved even over the previous editions published when he was Professor of Pathology at the University of Toronto.

Dr. Boyd stresses the fact that submission of tissue by the surgeon to the pathologist actually constitutes a consultation: an exchange of information. Referral is not simple routine presentation without any accompanied data. This is all too frequently neglected.

His comments about natural resistance are noteworthy. Dr. Boyd deplores the indiscriminate use of antibiotics and adds that as a result resistant bacterial organisms have developed in large numbers. Because of this, hospitals have become breeding grounds of bacterial strains resistant to chemotherapy. This can be blamed largely on inadequate dosage. Dr. Boyd advocates maximum doses but only for a short time.

The text is fully illustrated with 547 illustrations. An occasional microscopic reproduction is of inferior quality and not as clear as it should be. The illustrations of the gross specimens are well done. The references are recent and serve admirably as pointers for further reading. This book is an excellent addition to any physician's library. It serves not only as a textbook but also as a very readable refresher in pathology.

MURRAY W. SHULMAN, M.D.

Cornell Conferences on Therapy, Volume 7, 1955. Edited by H. Gold. Pp. 264. New York, The Macmillan Company, 1955. ($4.00)

This is the 7th annual report of conferences each headed by a moderator who calls upon an expert in that field. He initiates the topic with an exposition of the problems involved and a general review. There then ensues a period of questions and answers by the other panel members and the audience.

Topics for the directed discussions include the congestive failure with separate evaluation of various digitalis preparations and diuretic agents, and also one on quinidine therapy. The views on these and other subjects reflect the opinions of the Cornell group, thereby diminishing the total variety of views held in other centers on the matters discussed.

Also included are the choice of narcotic and anesthetic agents in shock, hints for the doctor's bag, management of pericardial effusion, therapy of

parasitic diseases, the treatment of headache and management of poisoning by insecticides. In addition, the treatment of intermittent claudication, use of physical therapy, hematemesis associated with portal hypertension and surgical treatment of mitral valvular disease are discussed.

An example of some of the topics investigated are the use of Diamox® as well as the mercurials as diuretics, the efficacy of the cardiac glycosides in the cardiac patient and the approach to a diuretic program in the edematous patient. The discussion of narcotics in shock offers helpful insights into experience with this problem. The application of sympathectomy to the patient with intermittent claudication and the value of conservative care makes for profitable reading. Useful also is the approach to medication in the management of patients complaining of headache.

The more lasting value of this book, which generally endorses the present orthodox forms of treatment, lies in two messages:

First, in its initial chapter, the problem of "how to evaluate a drug" is presented by a group of sophisticated therapists recalling to all the treacherous pathway of enthusiastic acclamation of medications whose evaluation is basically subjective. Too often the alleged benefits reflect the personality of the therapist. Those who administer the agent effect results through the wish to believe.

Second, there is a reevaluation of common therapeutic problems; emphasizing the deficits of therapy and reaffirming the rationale of treatment. The latter are too often relegated to a distant state through the economy of habit, to which the busy practitioner too easily succumbs, at the expense of thoughtful and meaningful reflection and questioning.

This volume is recommended to the practitioner who wants to keep abreast of current problems in therapy.

ALBERT MINZTER, M.D.

Of Water, Salt and Life: An Atlas of Fluid and Electrolyte Balance. Author not named. Published 1956 by Lakeside Laboratories, Milwaukee, Wisconsin. Pp. 72 ($7.50)

If you do not mind paying $7.50 for a slim, 72-page volume, this atlas is for you. By means of ingenious color diagrams it seeks to explain basic physiologic factors behind electrolyte balance. It portrays the pharmacology of diuresis. It illustrates the effects of water and salt depletion. It covers burns, shock, heat exhaustion, kidney diseases, liver cirrhosis and congestive heart failure. The subject is basically too complex to be explained in this primer fashion. But the anonymous author of this atlas comes closer to it than this reviewer has seen in any work of like size.

ULYSSES M. FRANK, M.D.

Operative Technic. Edited by Warren H. Cole, M.D. 2nd ed. Pp. 973. New York, Appleton-Century-Crofts, 1955. ($20.00)

The title of the volume, "Operative Technic" is completely inadequate to convey the great mountain of information between its covers. In addition to operative technic, Dr. Cole covers the pathological indications for each operation, the relevant anatomy and physiology, and related pre and postoperative problems. This is the general outline of the various sections dealing with the organ systems and added to these are sections on fundamentals such as shock, burns, transfusions and wound healing.

Quite wisely thoracic and vascular surgery are not included, having been placed in Volume Two. However, a short section on obliterative vascular disease, varicose veins and lumbar sympathectomy to replace a too long chapter on muscles and bursae (which is pure orthopedics) might make this book more valuable to the practicing general surgeon.

Any surgical resident will find "Operative Technic" helpful during his training. The surgeon in practice will find many occasions to refer to this comprehensive volume.

M. ALLYN ROBERTS, M.D.

Cancer Cells. By E. V. Cowdry, Ph.D. Pp. 677. Philadelphia, Saunders, 1955. ($16.00)

This large volume encompasses an extensive field of biological material and represents a vast amount of personal investigation and a review of the world literature on neoplasia. The personal nature of its informal style adds to its interest. You get the impression that this was not written but spoken during informal seminar sessions. Some of Dr. Cowdry's homely analogies and examples lead to picturesque but unscientific words and phrases, frequently with teleological and anthropromorphic implications. Thus, in discussing cancer cells such adjectives are used as criminal, anti-social, selfish, terms hardly applicable to objective evaluation of biological processes. Again, in discussing abnormal function of cancer cells, the author remarks that "relieved of helpful duties they embark upon a mad career of usurpation of prerogatives and of destruction of their neighbors . . . Cancer never will be controlled until we can reform the cancer cells, or make them submit to birth control or execute all of them as criminals."

But these are minor defects in this truly remarkable book. Experimental data obtained from animal investigation are frequently cited but the author is at all times cautious in drawing conclusions for the human on the basis of animal experiments. Sections are devoted to our present knowledge of the cancer cells including their function or lack of it, mode of spread, cytoplasmic constitution and metabolism as well as the anatomy and physiology of the nucleus and its components. Details of the

chemistry of cells and nuclei are included with emphasis on recent studies of enzymes and other modifiers. Several chapters review agents that have apparently caused cells to become malignant. These include exposure to solar, x-ray and atomic radiation, and carcinogens of external origin as industrial dyes or chemicals, tobacco smoke and airborne fumes, or of internal origin such as steroids. A chapter on the possible role of trauma in inducing tumor is of special interest. There is also an extensive discussion of viruses as cancer agents.

The mutation concept of carcinogenesis is fully evaluated and it is worthwhile to quote Cowdry on these theories: "It seems to an amateur that adherents of the mutation theory of cancer are not presenting their case with the fervor of those advocating the viral theory of the genesis of all cancers and are rather more open-minded. For the mutationists the advancement of the recently emerged and undeniably consequential science of genetics is their main concern. They appreciate, however, the bearing of their researchers on the etiology of cancer but they are not cytologists. The cancer virologists on the contrary seem to have for their abiding motive proof that all cancers of all animals and plants are caused by viruses. Their training in cytology is equally defective. There is much evidence on both sides." There are chapters on the heredity and the role played by age and sex. The geographic incidence of cancers is reviewed. The section on cancer prevention summarizes well whatever methods are available at present. Cancer diagnosis and treatment are adequately but not fully discussed. The chapter on research includes an interesting historical review as well as an extended exposition of present trends. The book has a pleasant format and a large bibliography and index.

GABRIEL YELIN, M.D.

A Doctor's Marital Guide for Patients. B. R. Greenblat, M.D. Chicago 1956. The Budlong Press. Pp. 88. Paper. ($1.50)

In forthright if somewhat mechanical fashion the author explains the technic of coitus, the anatomy and physiology of pregnancy, and the problems of impotence, premature ejaculation and other obstacles to a full sex life. Dr. Greenblat recognizes the emotionally enriching potential of a full love relationship. He does his best to indicate that these simple hints on how to improve your sex relations are not enough. I doubt that "the cause of juvenile delinquency . . . is frequently the parents' confusion and anxiety on sex." But apart from this minor crotchet, the author is solid in his approach. A general practitioner, an obstetrician or a gynecologist could do worse than present young married or betrothed couples in his practice with copies of this booklet.

VICTOR HUBERMAN, M.D

Sleep. By Marie C. Stopes. New York 1956. Philosophical Library. Pp. 153. ($3.00)

Marie Stopes was a gallant fighter in a good cause, and we all salute her for her courage. Now, at the age of 77, she has allowed a publisher to talk her into releasing this collection of old wives' tales. She says that beds should be placed in the north-south axis, because you "magnetate" the north between the shoulder and the hips. And don't sleep on foam rubber or have rubber tires on bed casters because this insulates you from the earth's natural electricity! To sleep well, Mrs. Stopes recommends keeping a clock that ticks at a rate slower than your heart beat, wearing pure silk night clothes (not rayon or artificial silk, she says, but only silk made by silk worms), eating a raw egg before retiring, having an open but unused fireplace in the room (better ventilation) and keeping a bed-pan or chamber pot handy to obviate the walk to the toilet.

She believes that these things cause insomnia: pyjamas, sleeping in an east-west axis, sleeping on foam rubber mattresses, long engagements, hot water bottles in bed (the chemical fumes, you know), eating lobster salad at night, and double beds. With respect to the last point, Mrs. Stopes' suggestion is that "the wife have a double bed, but the husband have a bedroom of his own for general use, keeping his wife's bedroom available as a romantic place."

There is something poignantly pathetic about seeing this once-great name signed to 150 pages of such nonsense.

HENRY A. DAVIDSON, M.D.

ANSWERS TO THE HOSPITAL QUIZ

1. (d)	5. (a)	9. (b)	13. (e)
2. (c)	6. (c)	10. (a)	14. (b)
3. (e)	7. (b)	11. (b)	
4. (c)	8. (e)	12. (c)	

TUBERCULOSIS *Abstracts*

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ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XXIX November, 1956 No. 11

Acceptable Standards in the Treatment of Tuberculosis

A Joint Statement of the Committees on Therapy and on Administrative Problems of the American Trudeau Society, *American Review of Tuberculosis and Pulmonary Diseases, April, 1956.*

This statement represents the joint and considered opinion of the American Trudeau Society Committees on Therapy and on Administrative Problems.

In recent years the discussion of hospital and home care of patients with tuberculosis has tended to cloud certain concepts which need re-emphasis.

Tuberculosis remains a chronic, infectious disease. It requires long and continuous treatment. The physician should be assured of the cooperation of the patient and family. This is necessary to be sure that the treatment and other recommendations made will be followed in compliance with good clinical and preventive medical practices and the regulations of the local Boards of Health.

Good medical practice requires the maximum facilities for clinical evaluation of a case, which, in most instances, can be done best in the hospital where appropriate treatment can be started. Preferably it should be continued until the patient's condition is satisfactorily stabilized. Now with more effective treatment methods, it may be reasonable to modify the period of hospitalization for certain selected cases. The treatment of tuberculosis remains difficult and the results in individual cases are frequently unpredictable. When home care is used, it must be carefully coordinated with hospital care, particularly during treatment of the active stages.

To secure the best results, certain standards must be met:

1. *Medical care.* The patient should be under the continuous supervision of a well-trained physician or group of physicians who thoroughly understand the care, management, and treatment of tuberculosis. As most cases will involve both hospital and home care, there must be maximum coordination of inpatient and outpatient services and careful cooperation with the private physician in the approach to this treatment.

2. *Diagnosis.* Facilities must be available for the diagnosis and subsequent management of all patients. These would include readily available roentgenographic examinations with facilities for special examinations, such as stereoscopic films, planigraphy, fluoroscopy, and other needed measures. Provisions must be made for clinical laboratory examinations, biopsy, bronchoscopy, and other necessary tests so frequently required to make a correct diagnosis.

3. *Isolation.* Tuberculosis remains a communicable disease and this fact needs to be kept continuously in mind. Facilities must be available for the isolation of the patient to protect the members of his family and the public. It must be remembered that sputum often does not become negative for *M. tuberculosis* during the first several months of treatment and too frequently fails to convert in advanced cases even under the best therapy.

4. *Nursing.* Rest and nursing care must be assured for the patient. Provisions for rest must include both physical relaxation and psychological rest with all that this implies. Nursing care includes not only the physical aid given by the nurse to the patient, but also the assistance to the physician in the education of the patient concerning his disease and the necessity for treatment.

5. *Nutrition.* A well-balanced diet is a necessity. Assistance in the selection and preparation of this diet will be needed, particularly in the early months of therapy.

6. *Drug therapy.* Antimicrobial therapy must be available for long-term, continuous treatment in accordance with accepted regimens. The drug regimen should be determined on medical factors alone, and should not be influenced by the convenience of the patient, physician, or nurse. *Once started, antimicrobial treatment should be continued without interruption as long as medically indicated.*

7. *Sputum examinations.* Laboratory facilities must be available to provide periodic examinations of sputum or gastric contents at regular intervals. This will vary from frequent examinations at the start of treatment to at least bimonthly examinations after several months. Studies must include cultures at regular intervals, especially when smears are negative for *M. tuberculosis.* Cultures of positive sputum are necessary for diagnostic identification, viability, and drug-susceptibility tests. It is advisable to include the studies of the bacilli for drug susceptibility, and the results should be evaluated in conjunction with clinical data. Alterations in therapy should not be made hastily on the basis of these results alone. Other laboratory studies to detect early evidences of drug resistance should be made.

8. *Surgery.* Surgical consultations should be held early and often, in view of the large number of patients who require surgery. There must be access without delay to hospitals well equipped for thoracic surgery.

9. *Adjunct services.* All auxiliary services such as recreation, occupational therapy, education, medical social service, and rehabilitation should be available from the beginning of the treatment period.

10. *Follow-up.* Long-term clinical, radiographic, and bacteriologic follow-up is essential after the patient returns to community life and should be available in order to detect a possible relapse.

11. *Patient education.* It is essential for the patient to understand his disease for successful and permanent recovery. Patient education by the physician, assisted by the nurse and others, thus becomes of major importance in treatment.

The patient with tuberculosis needs all of the above-mentioned services during various periods of his disease and treatment. Neither home care nor hospital care that fails to provide these services can be considered adequate at this time. It has not yet been proved that even the less destructive forms of tuberculosis can be treated adequately without these aids, although many studies are now in progress.

Most patients would benefit and could be assured of better success if treatment were initiated and continued in a hospital for as long as indicated before being continued in the home. It seems obvious that these necessary facilities and services can best be provided in a hospital during the active stages of the disease. During subsequent phases, these services should be made available to the patient at home.

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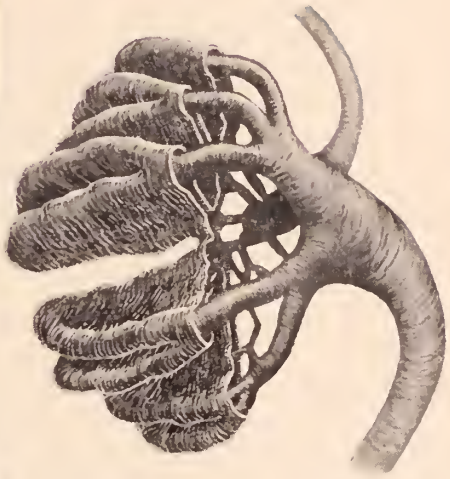
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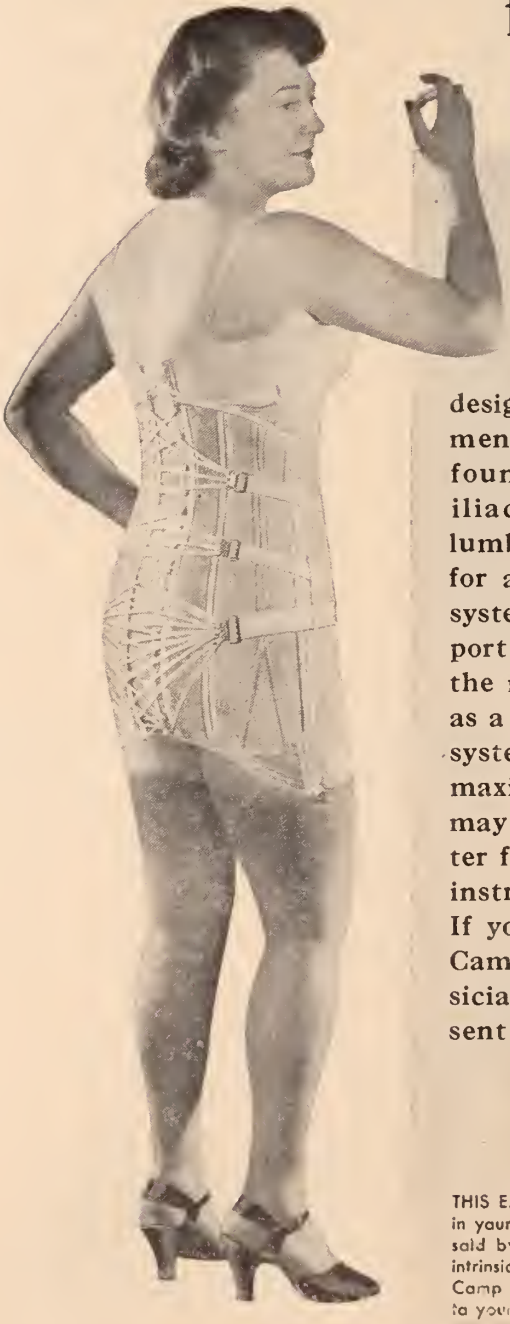
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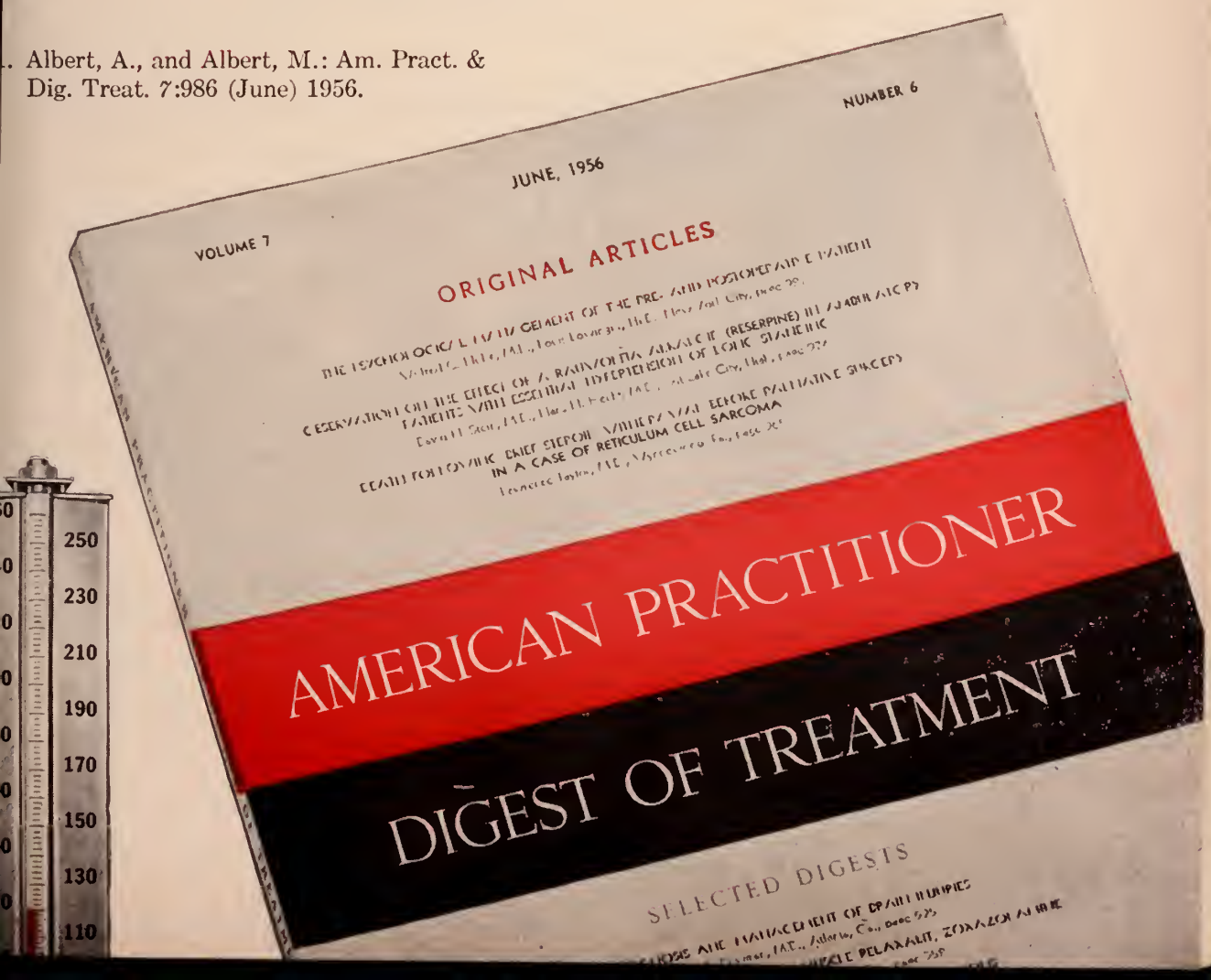
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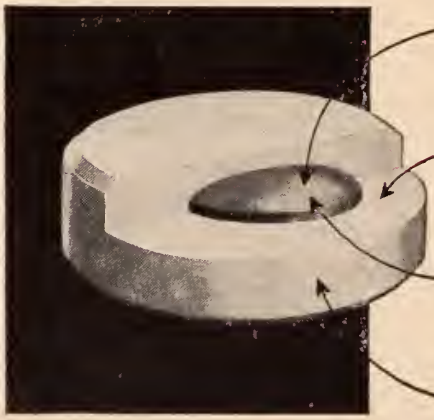
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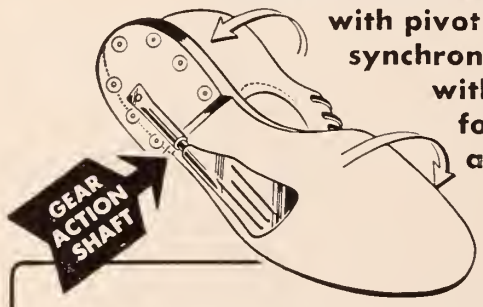
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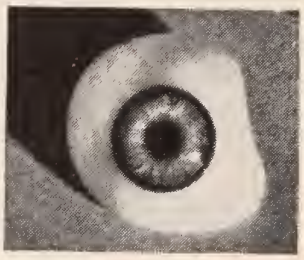
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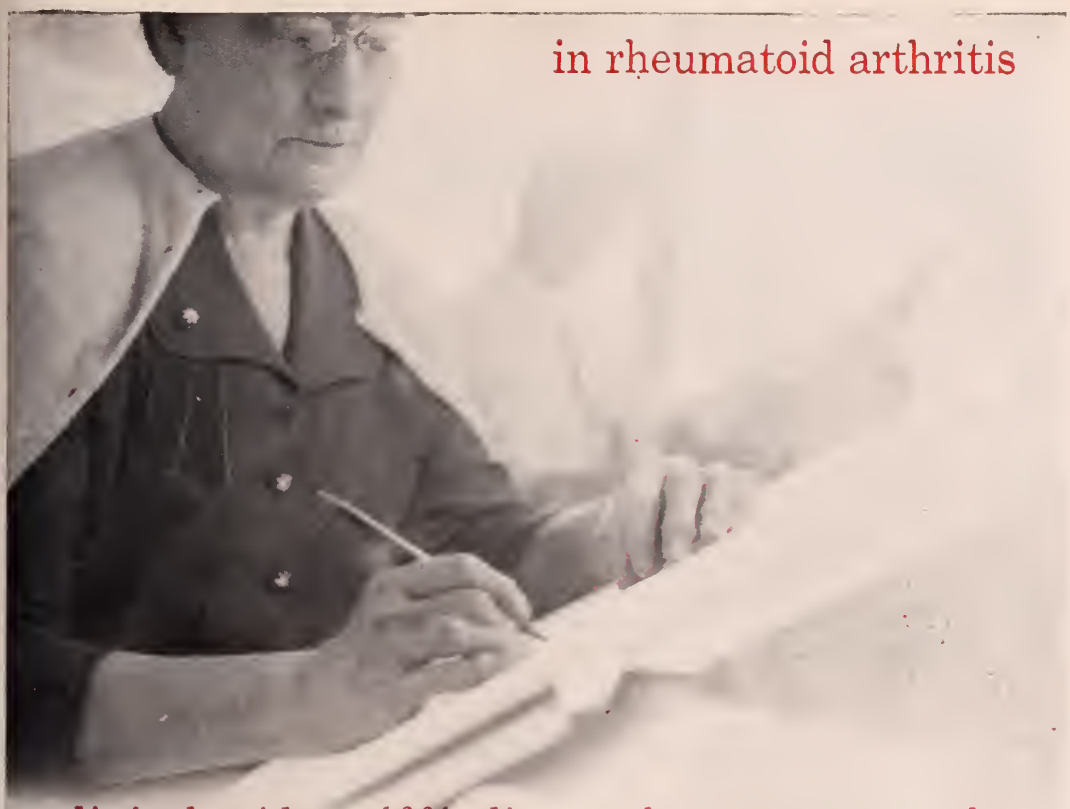
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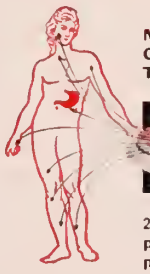


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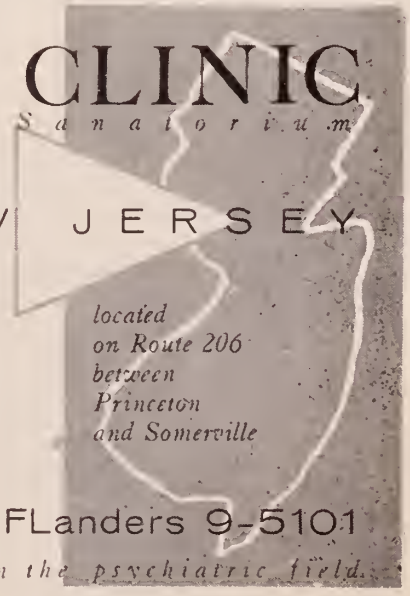
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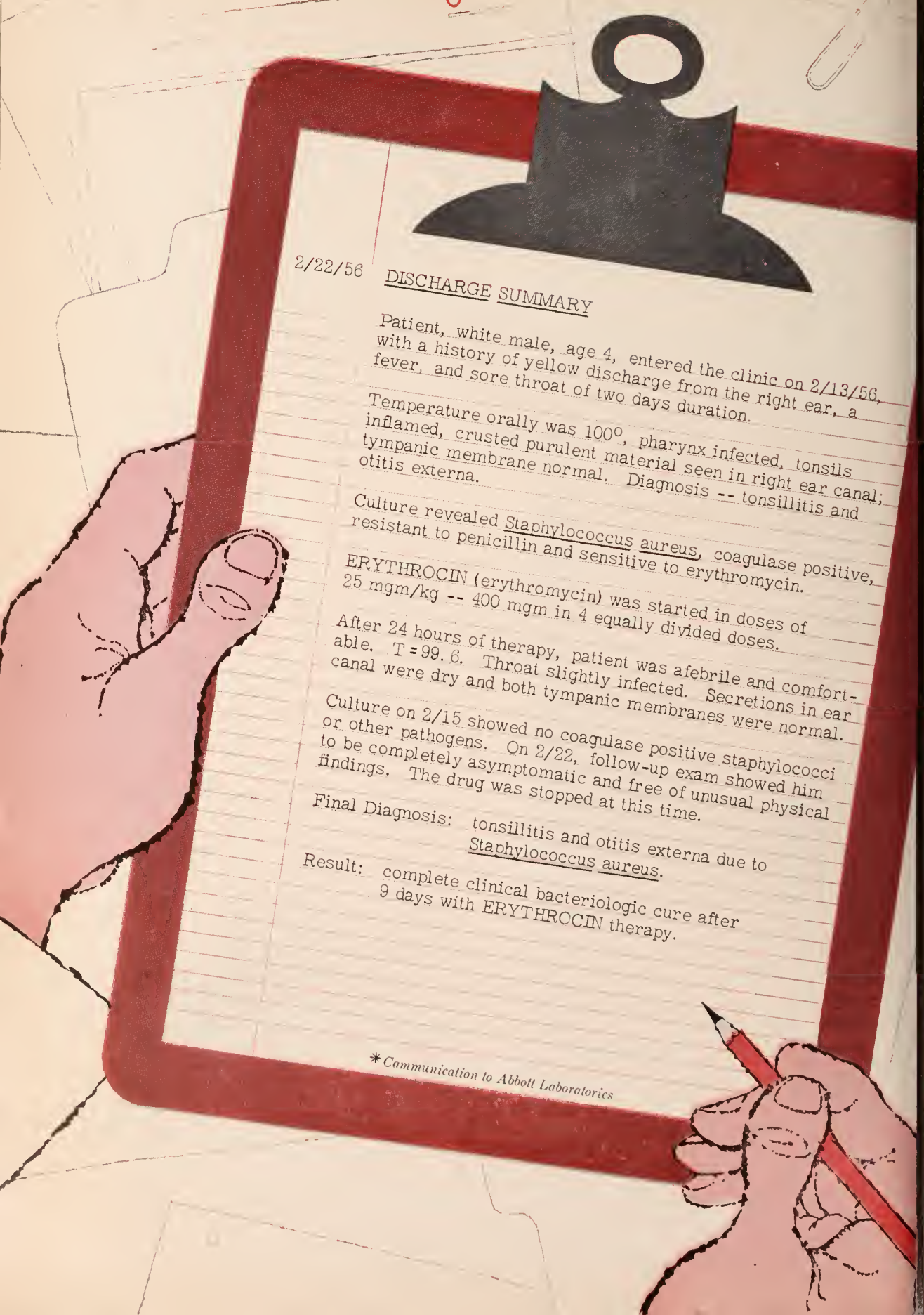
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1. Finland, M., *et al.*: *J.A.M.A.* 154:561 (Feb. 13) 1954.
2. Prigot, A. and Marmell, M. *Antibiotics and Chemotherapy* 4:1117 (Oct.) 1954.
3. Trafton, H. and Lind, H.: *idem* 4:697 (June) 1954.
4. English, A., *et al.*: *idem* 4:441 (April) 1954.

Erythrocin in treating tonsillitis and otitis exter



2/22/56 DISCHARGE SUMMARY

Patient, white male, age 4, entered the clinic on 2/13/56, with a history of yellow discharge from the right ear, a fever, and sore throat of two days duration.

Temperature orally was 100°, pharynx infected, tonsils inflamed, crusted purulent material seen in right ear canal; tympanic membrane normal. Diagnosis -- tonsillitis and otitis externa.

Culture revealed Staphylococcus aureus, coagulase positive, resistant to penicillin and sensitive to erythromycin.

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1. Herrell, W. E., Erythramycin, Antibiatics Monagraphs, No. 1, p. 29, New Yark, Medical Encyclapedia, Inc., 1955.
Idem p. 30.

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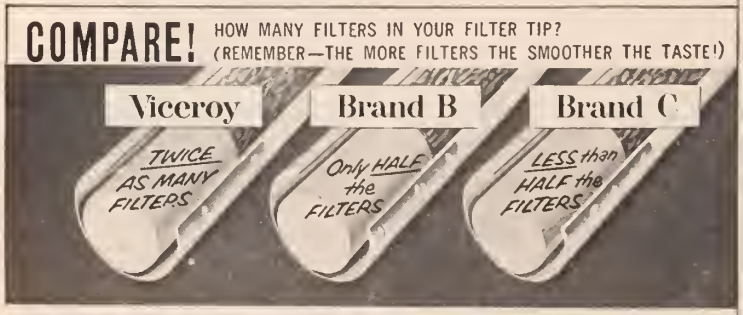


Twice as Many Filters

AS THE OTHER TWO LARGEST-SELLING FILTER BRANDS

For the Smoothest Taste in Smoking!

COMPARE! HOW MANY FILTERS IN YOUR FILTER TIP? (REMEMBER—THE MORE FILTERS THE SMOOTHER THE TASTE!)



VICEROY'S EXCLUSIVE FILTER IS MADE FROM PURE CELLULOSE—SOFT, SNOW-WHITE, NATURAL!



Upjohn

Rheumatoid arthritis, rheumatic fever, intractable asthma, allergies . . .

Cortef* *tablets*

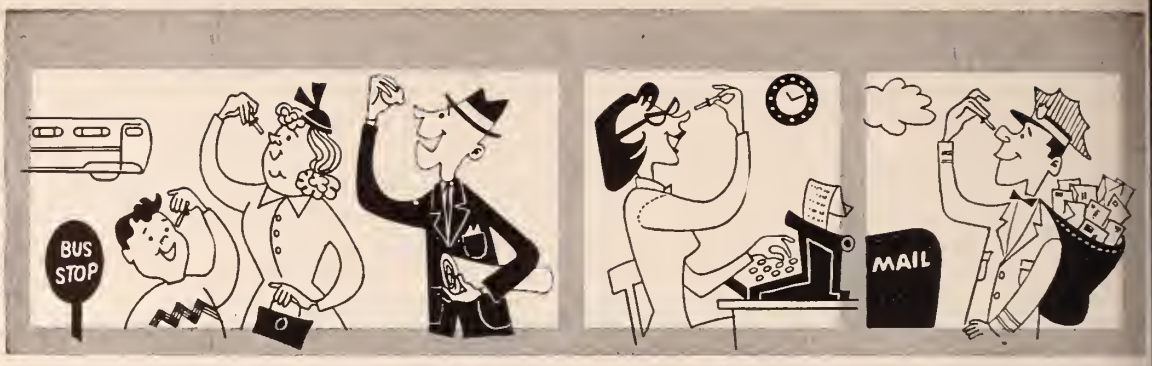
Supplied:

5 mg. tablets in bottles of 50
10 mg. tablets in bottles of 25, 100, 500
20 mg. tablets in bottles of 25, 100, 500

*REGISTERED TRADEMARK FOR THE UPJOHN BRAND OF HYDROCORTISONE (COMPOUND F)

The Upjohn Company, Kalamazoo, Michigan





In Colds . . . *Anywhere . . . Any time . . .*

Neo-Synephrine®

hydrochloride

Prompt and Prolonged Decongestion
Sinus Drainage and Aeration

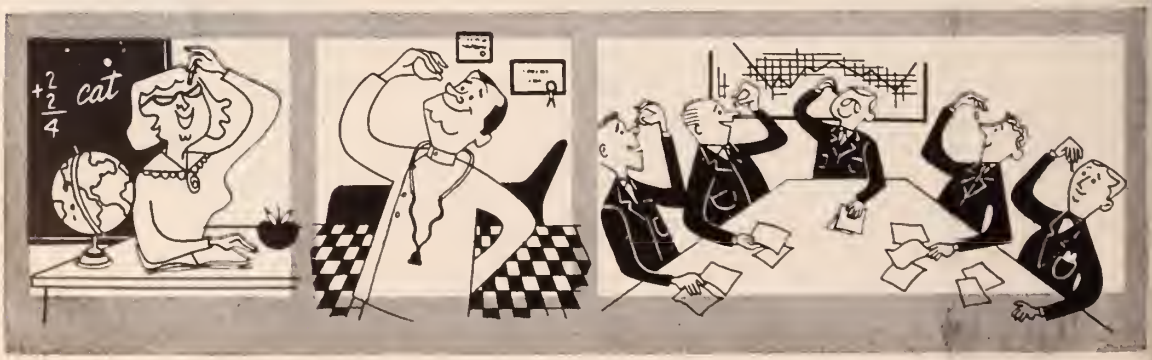
NO IRRITATION • NO SEDATION • NO EXCITATION

- ✻**Nasal Solutions** 0.25%, 0.5% and 1%
- ✻**Nasal Spray** 0.5%
- ✻**Pediatric Nasal Spray** 0.25%, with Zephiran® chloride 1:5000, antibacterial wetting agent and preservative for greater efficiency

} *plastic, unbreakable squeeze bottle leakproof, delivers a fine mist*

Neo-Synephrine (brand of phenylephrine) and Zephiran (brand of benzalkonium, as chloride, refined), trademarks reg. U.S. Pat. Off.

Winthrop LABORATORIES
NEW YORK 18, N. Y. • WINDSOR, ONT.



relaxes
both mind
and
muscle

for the average patient in everyday practice

- well suited for prolonged therapy
- well tolerated, nonaddictive, essentially nontoxic
- no blood dyscrasias, liver toxicity, Parkinson-like syndrome or nasal stuffiness
- chemically unrelated to chlorpromazine or reserpine
- does not produce significant depression
- orally effective within 30 minutes for a period of 6 hours

Indications: **anxiety and tension states, muscle spasm.**

THE ORIGINAL MEPROBAMATE

Miltown®

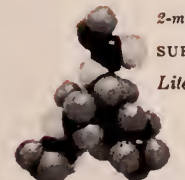
Tranquilizer with muscle-relaxant action

DISCOVERED AND INTRODUCED
BY WALLACE LABORATORIES, *New Brunswick, N.J.*

2-methyl-2-n-propyl-1,3-propanediol dicarbamate—U.S. Patent 2,724,720

SUPPLIED: *400 mg. scored tablets. Usual dose: 1 or 2 tablets t.i.d.*

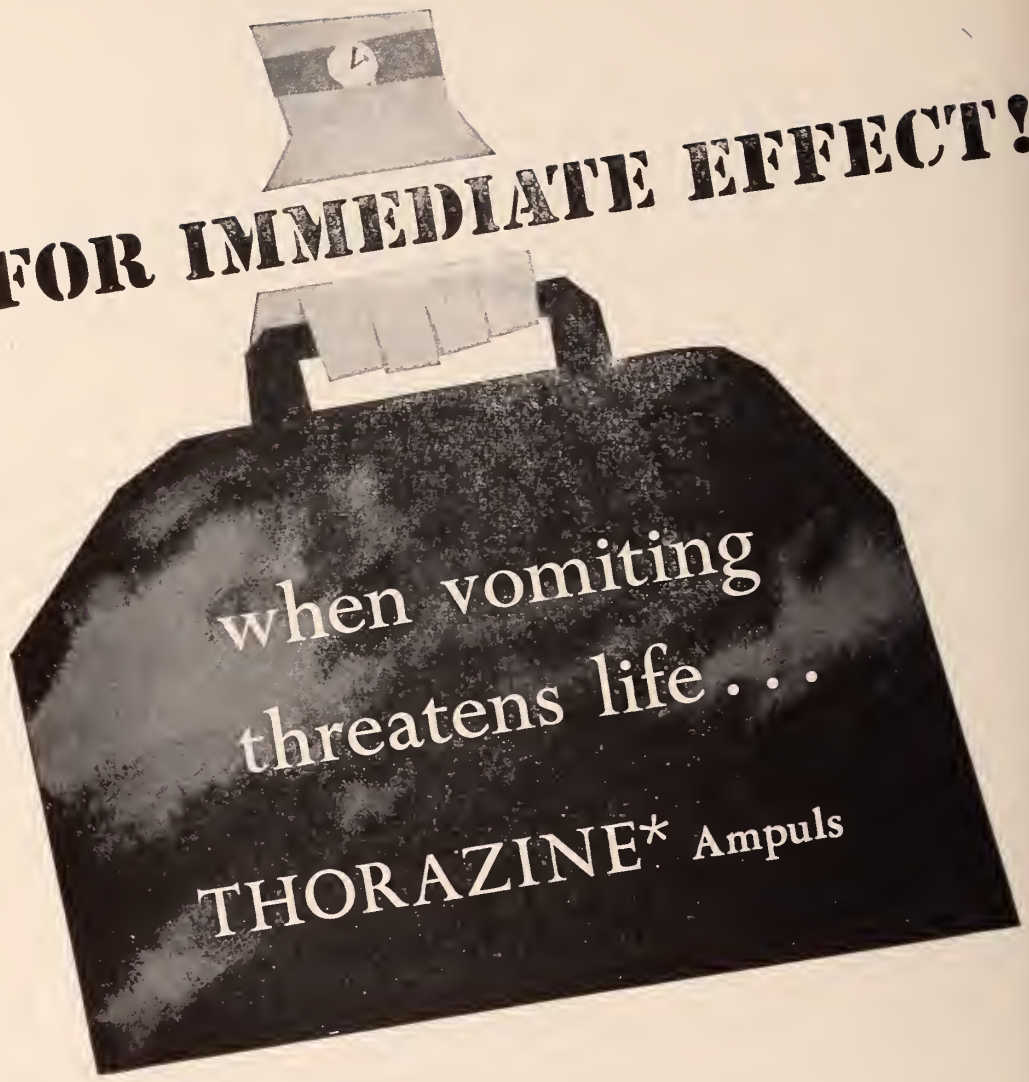
Literature and Samples Available on Request



THE MILTOWN MOLECULE

CM-3706-R2

FOR IMMEDIATE EFFECT!



'Thorazine' should be administered discriminately and, before prescribing, the physician should be fully conversant with the available literature.

always carry 'Thorazine' Ampuls in your bag

Smith, Kline & French Laboratories, Philadelphia

*T.M. Reg. U.S. Pat. Off. for chlorpromazine, S.K.F.

in inflammatory skin diseases



all the benefits of the "predni-steroids"
plus positive antacid action
to minimize gastric distress

ROUTINELY ACHIEVED WITH

'Co-Deltra'

(Buffered Prednisone)



Multiple Compressed Tablets



'Co-Hydeltra'

(Buffered Prednisolone)

2.5 mg. or 5 mg. prednisone or prednisolone with 50 mg. magnesium trisilicate and 300 mg. aluminum hydroxide gel.

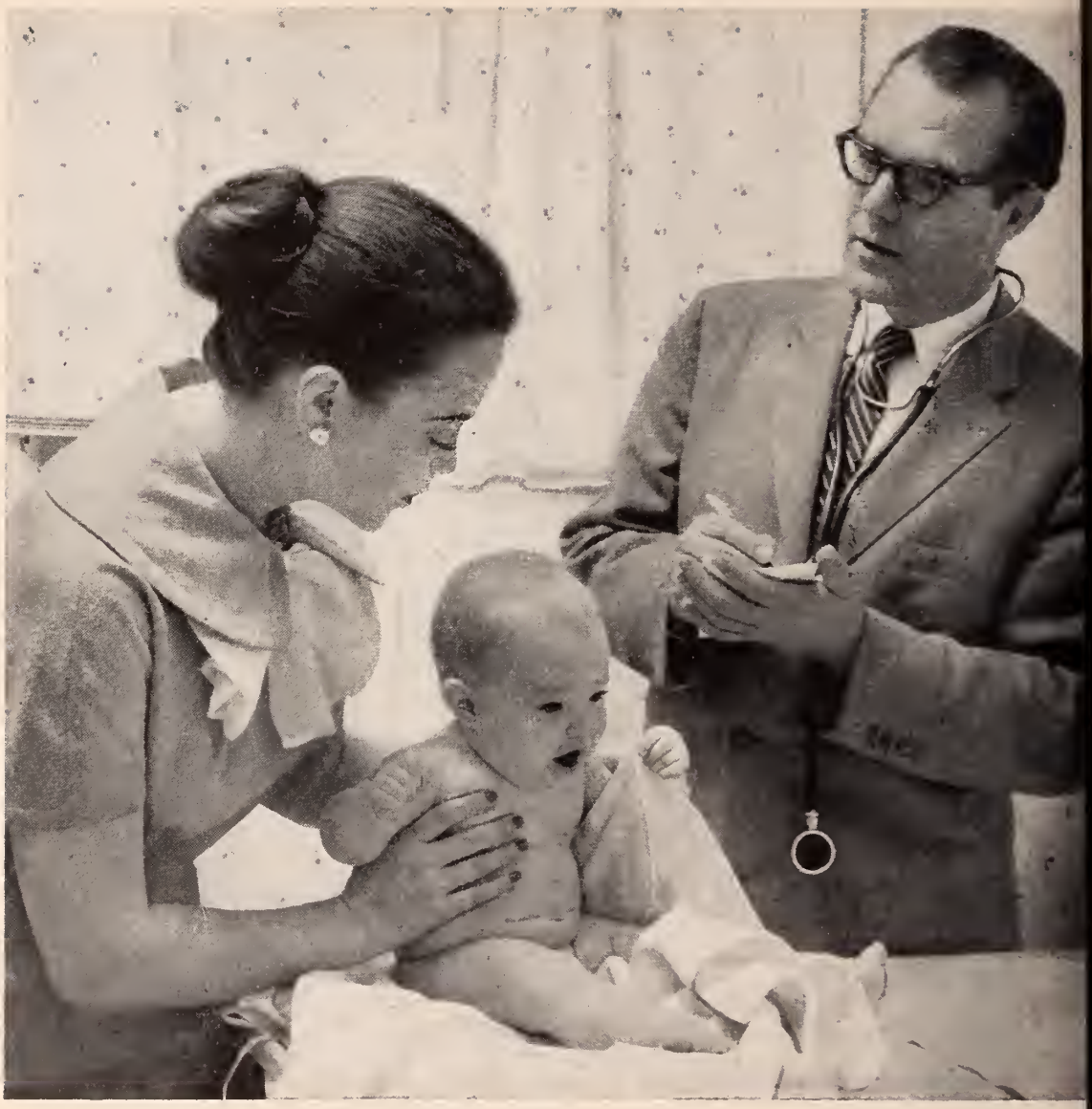
Clinical evidence[1,2,3] indicates that to augment the therapeutic advantages of prednisone and prednisolone, antacids should be *routinely* co-administered to minimize gastric distress.

References: 1. Boland, E. W., *J.A.M.A.* 160:613, (February 25,) 1956. 2. Margolis, H. M. *et al*, *J.A.M.A.* 158:454, (June 11,) 1955. 3. Bollet, A. J. *et al*, *J.A.M.A.* 158:459, (June 11,) 1955.

MSD

MERCK SHARP & DOHME
DIVISION OF MERCK & CO., INC.
PHILADELPHIA 1, PA.

'CO-DELTRA' *and* 'CO-HYDELTRA' *are the trademarks of* MERCK & CO., INC.



KARO®... meets the need for a completely assimilable carbohydrate in infant feeding

Physicians and parents alike appreciate the efficacy, convenience and economy of Karo Syrup. For this double-rich, readily miscible mixture of dextrin, maltose and dextrose is easily digested, well tolerated and completely utilized.

Three generations of use as a milk modifier have shown that even premature babies thrive on Karo... and that its use does not induce flatulence, colic, fermentation or allergy.

Karo permits easy adjustment of formula and transition from liquid to solid food as circumstances demand. It may be used with sweet, acid, evaporated, dried or protein milk. Light or dark Karo each supply equivalent nutritive and digestive values... yielding 60 calories per tablespoonful.



1906 • 50th ANNIVERSARY • 1956
CORN PRODUCTS REFINING COMPANY
17 Battery Place, New York 4, N. Y.

Symptomatic relief...plus!



Achrocidin*

Tetracycline-Antihistamine-Analgesic Compound

ACHROCIDIN is a comprehensive formula for treatment of complications of the common cold, particularly when bacterial sequelae are observed or expected from the patient's history or during widespread infections.

Distressing symptoms of malaise, headache, muscular pain, mucosal and nasal discharge are rapidly relieved.

And potent prophylaxis is offered against other diseases, such as otitis media, sinusitis, adenitis, and bronchitis, to which the patient may be highly vulnerable at this time.

ACHROCIDIN is convenient for you to prescribe—easy for the patient to take. Average adult dose: two tablets four times daily.

Available on prescription only

Each tablet contains:

ACHROMYCIN® Tetracycline	125 mg.
Phenacetin	120 mg.
Caffeine	30 mg.
Salicylamide	150 mg.
Chlorothen Citrate	25 mg.

Bottle of 21 tablets

Lederle LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, N. Y.

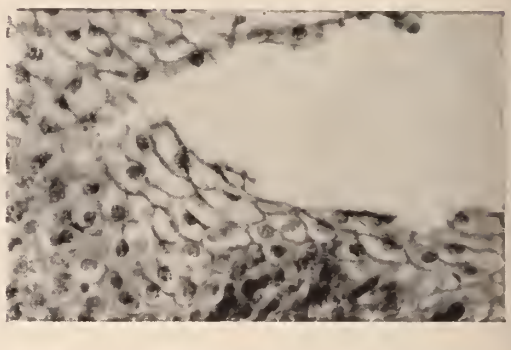
*TRADEMARK

HOW VAGISEC LIQUID

PENETRATES

RECESSES OF VAGINA AND EXPLODES TRICHOMONADS OFTEN MISSED

Photomicrograph of section of epithelium of normal vaginal mucosa, enlarged 750 times, shows uneven surface where trichomonads hide. VAGISEC penetrates surface and explodes organisms in hard-to-reach areas.



TOO OFTEN AN ORDINARY trichomonacide fails to cure vaginal trichomoniasis because it has little or no effect on parasites that are not on the surface.[1] Trichomonads burrowed deeply into the roughened mucosa survive and set up new foci of infection. In fact, even a few hidden trichomonads remaining after treatment can cause acute exacerbations. With VAGISEC® liquid and jelly you can overcome this most troublesome problem.

Penetrates thoroughly — This new and unique trichomonacide spreads out and wets the entire vaginal surface. It rapidly dissolves mucinous materials, fats and blood clots.[1] It penetrates the cellular debris that lines the vaginal walls and shields the parasites, reaching trichomonads deep in their hiding places.

Explodes trichomonads — VAGISEC liquid actually explodes trichomonads within 15 seconds after douche contact.[2] Two surface-acting agents and one chelating agent combine to weaken the cell membrane, to remove the waxes and lipids, and to denature the protein. With its cell wall destroyed, the parasite imbibes water, swells and explodes. All this occurs within 15 seconds. Only scattered fragments remain.

Proves highly effective — With the Davis technique† you can now rid patients of "trich," even cases that have resisted other treatment. VAGISEC liquid was developed as "Carlendacide," by Dr. Carl Henry Davis, M.D., noted gynecologist and author, and C. G. Grand, research physiologist.[1] Clinical trials by more than 150 physicians show better than 90 per cent success.[3]

Use liquid and jelly — In the Davis technique, VAGISEC liquid is used in office therapy. At the same time, liquid and jelly are prescribed for home use. They are well tolerated, leave no messy discharge or stain.

Office treatment — Expose vagina with speculum and wipe walls dry with cotton balls. Then wash thoroughly with a 1:100 dilution of VAGISEC liquid. Remove excess fluid with cotton balls. Dr. Davis recommends six treatments.

Home treatment—Patient douches with VAGISEC liquid every night or morning and then inserts VAGISEC jelly. Home treatment is continued through two menstrual periods, but omitted on office treatment days. Douching contraindicated in pregnancy.

One course of treatment—"If the treatment has been accomplished as directed," the patient "will have no flagellates provided the infection was limited to the vaginal canal . . . A few women have infected cervical, vestibular or urethral glands and require other types of treatment."[4] Continued douching with VAGISEC liquid two or three times each week for eight to twelve weeks helps prevent re-infection.

Prevents coital re-infection — Infected husbands are ". . . a potential source of re-infection in wives successfully treated."[5] Prescribe for your patients the protection afforded by Schmid high quality prophylactics. Specify the superior RAMSES® rubber prophylactic, transparent, tissue-thin, yet strong. If there is anxiety that rubber might dull sensation, prescribe XXXX (FOUREX)® prophylactic skins, of natural animal membrane, pre-moistened.

Active ingredients in VAGISEC liquid: Polyoxyethylene nonyl phenol, Sodium ethylene diamine tetra-acetate, Sodium dioctyl sultosuccinate. In addition, VAGISEC jelly contains Boric acid, Alcohol 5% by weight.

References: 1. Davis, C. H., and Grand, C. G.: Am. J. Obst. & Gynec. 68:559 (Aug.) 1954. 2. Davis, C. H.: J.A.M.A. 157:126 (Jan. 8) 1955. 3. Davis, C. H.: West. J. Surg. 63:53 (Feb.) 1955. 4. Davis, C. H. (Ed.): Gynecology and Obstetrics (revision), Hagerstown, W. F. Prior, 1955, vol. 3, chap. 7, pp. 23-33. 5. Lanceley, F., and McEntegart, M. C.: Lancet 1:668 (Apr. 4) 1953.

JULIUS SCHMID, INC
gynecological division
423 West 55th Street, New York 19, N. Y.

VAGISEC, RAMSES and XXXX (FOUREX) are registered trade-marks of Julius Schmid, Inc.
†Pat. App. for

new

LIPO GANTRISIN 'Roche'

Only two doses a day for round-the-clock effect

When you prescribe Lipo Gantrisin, your patients usually need only two doses daily, for the antibacterial action of a single dose

lasts for twelve hours. Lipo Gantrisin 'Roche' is a palatable liquid especially useful for children and elderly invalids.

Lipo Gantrisin® Acetyl — brand of acetyl sulfisoxazole in vegetable oil emulsion

For patients pursued by their own emotions —

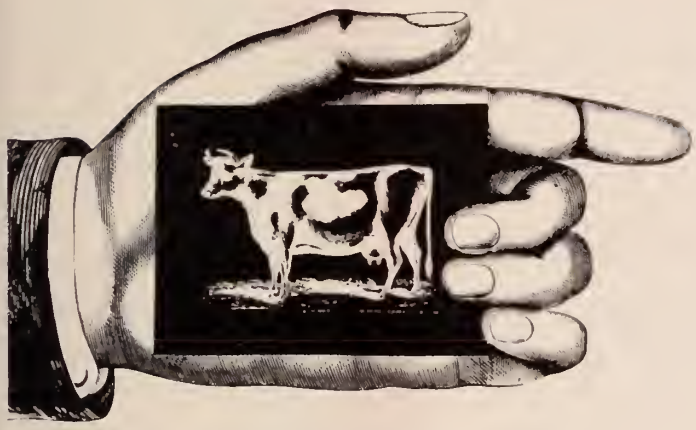


Noludar 'Roche' will help solve the problem. Not a barbiturate, not likely to be habit forming, 50 mg t.i.d. provides daytime sedation with little likelihood of somnolence, while 200 mg h.s. induces a sound night's sleep, usually without hangover. Noludar tablets, 50 and 200 mg; elixir, 50 mg per teaspoon.

Hoffmann - La Roche Inc.
Nutley 10, New Jersey

Noludar®--
brand of methyprylon

We've given the cow a hand!



HI-PRO Spray Dried Modified Cow's Milk takes up where cow's milk leaves off. It gives a 3-to-1 protein-to-fat ratio to patients in need of biologically complete protein content and low fat intake.

HI-PRO provides a full quota of calories without danger of fat irritation in cases of fat intolerance or where digestive disturbances are present. Readily digestible, it is ideal in treatment of infant diarrhea, prematures, fat intolerance and normal newborns.

infant diarrhea
Proteins are well-absorbed and supply calories lost by reduction in fat and carbohydrates.

prematures
Rapid growth plus low fat tolerance makes HI-PRO an ideal food.

fat intolerance
Protein is well-absorbed and caloric intake can be raised to any level without fat difficulties.

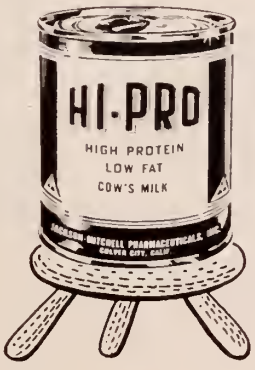
normal newborns
With HI-PRO, you can provide extra protein without fat for rapid growth and good tissue turgor.

hi-pro, analysis—dry

Protein	41%
Fat	14%
Carbohydrate	35%
Calcium	1.15%
Calories per oz.	121

For complete literature and samples write:
JACKSON-MITCHELL
Pharmaceuticals, Inc.
Culver City, California

Serving the Medical Profession Since 1934



HI-PRO is available in 1-lb. and 2½-lb. vacuum-packed tins at all pharmacies.

a new maximum
in therapeutic
effectiveness

a new maximum
in protection
against
resistance

a new maximum
in safety and
toleration



multi-spectrum
synergistically
strengthened...

Sigma

OLEANDOMYCIN TETRACYCLINE

ient
pulation



nycin*

a new certainty

in antibiotic therapy, particularly for the 90% of patients treated at home and in the office

Superior control of infectious diseases through superior control of the changing microbial population is now available in a new formulation of tetracycline, outstanding broad-spectrum antibiotic, with oleandomycin, Pfizer-discovered new antimicrobial agent which controls resistant strains. The synergistic combination now brings to antibiotic therapy: (1) a new fuller antimicrobial spectrum which includes even "resistant" staphylococci; (2) new superior protection against emergence of new resistant strains; (3) new superior safety and toleration.

*TRADEMARK

Pfizer

From your patient's viewpoint, Doctor . . .

is this the painful part of the treatment?

It can be, unless your patients know the true facts about the cost of medical care. Parke-Davis is reaching millions of people, in LIFE, SATURDAY EVENING POST and TODAY'S HEALTH, with a consistent advertising campaign whose theme is "prompt and proper medical care can be one of life's biggest bargains."

In addition to the magazine advertisements, Parke-Davis makes folder-reprints available for use in pharmacies. Chances are, a large percentage of the prescriptions you write are being packaged with one of these folders explaining the value of modern prescription medicines—reaching your patients right at the time when they are most conscious of the cost. To date, more than six million of these folders have been ordered by pharmacists.

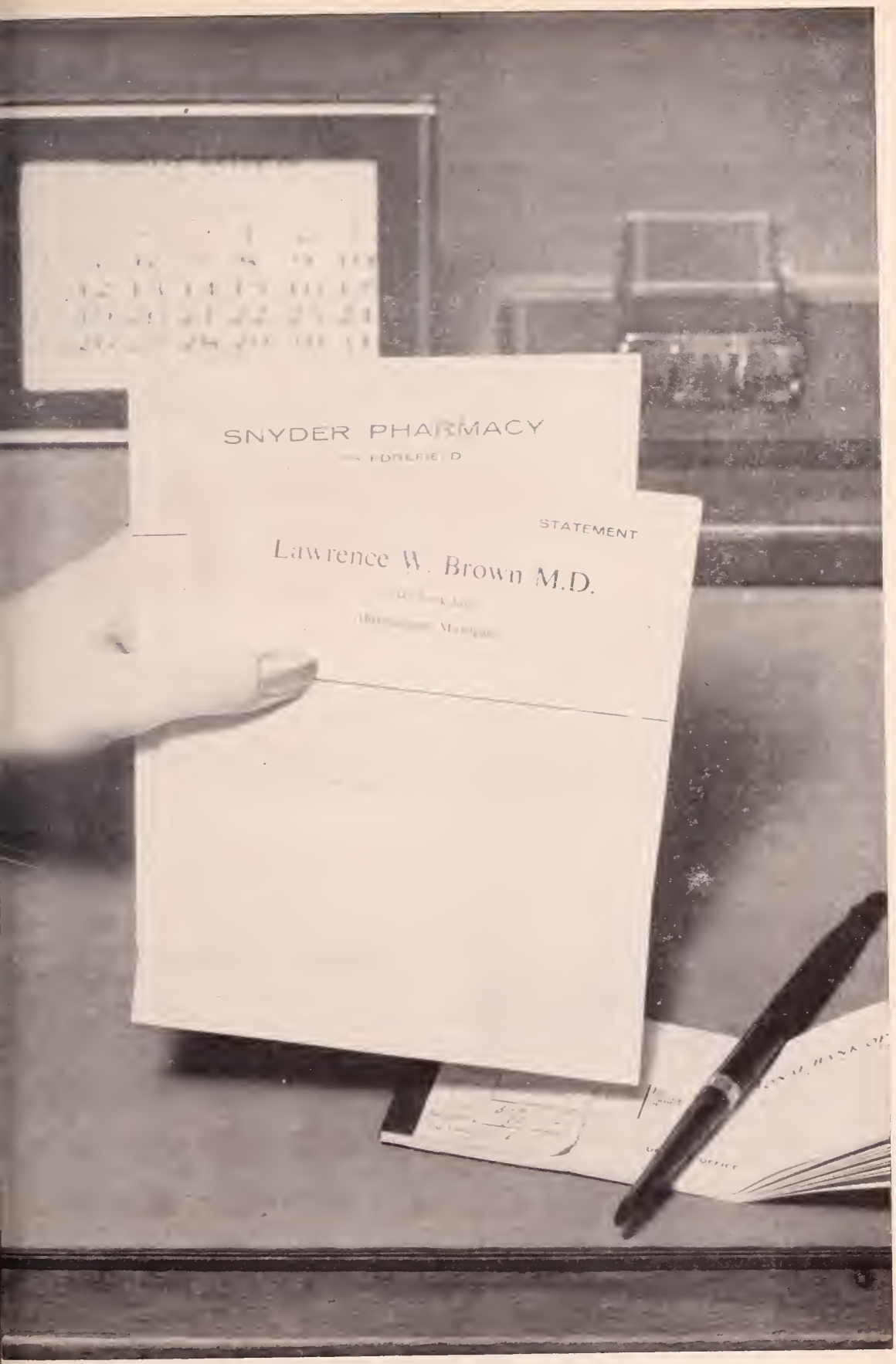
In these advertisements, we strive to present the facts about medical care clearly and unemotionally . . . with the objective of increasing the public's appreciation of why costs and procedures involved are reasonable and fair.



PARKE, DAVIS & COMPANY

Detroit 32, Michigan

If you would like reprints of this Parke-Davis "cost of medical care" series, just drop us a line.


SNYDER PHARMACY
STATEMENT
Lawrence W. Brown M.D.

NEW

For Pain-F

of every

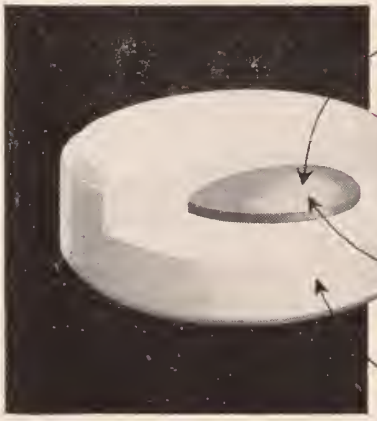
In "Rheumatism

Mult

TEMP

combine:

THE PROPER FORMULA
PROPERLY FORMULATED



PREDNISOLONE (

+

ASPIRIN (*0.3 Gm.*) . . . .

+

ASCORBIC ACID (

+

ANTACID (*0.2 Gm.*) . . . . .

Physical separation of the steroid component from the aluminum hydroxide as provided by the Multiple Compressed Tablet construction assures full potency and stability of prednisolone.

*Early rheumatoid arthritis
Rheumatoid spondylitis
Osteoarthritis
Still's disease
Psoriatic arthritis
Bursitis
Synovitis
Tenosynovitis
Myositis
Fibrositis
Neuritis

formance

ities

ients



pressed **T***ablets*

OGEN®

. . . for anti-inflammatory, anti-rheumatic benefits *at effective low dosage.*

. . . for analgesia plus additional anti-rheumatic activity.

. . . for anti-stress support that guards against adrenal ascorbic acid depletion.
(Ascorbic Acid present as 60 mg. Sodium Ascorbate.)

. . . dried aluminum hydroxide gel minimizes the possibility of gastric distress.

DOSAGE: *1-4 TEMPOGEN Tablets t.i.d. or q.i.d. (TEMPOGEN Forte, 1 or 2 tablets t.i.d. or q.i.d.) for one or two weeks. Then lower by 1 tablet every four or five days to maintenance level.*

SUPPLIED: *TEMPOGEN and TEMPOGEN Forte —in bottles of 100 Multiple Compressed Tablets. (TEMPOGEN Forte provides 2 mg. of prednisolone.)*

MSD

MERCK SHARP & DOHME
DIVISION OF MERCK & CO., INC.
PHILADELPHIA 1, PA.

individualized *use of rauwolfia in the management of hypertension*

Rauval®
(Rauwolfia Serpentina)



contains all the therapeutically active alkaloids of whole powdered *Rauwolfia serpentina* (double-assayed) to provide a unique balance of hypotensive and sedative benefits.[1] Bottles of 100 and 1000 sugar-coated tablets: 50-mg. red and 100-mg. pink tablets.

Rauprote
(Rauwolfia Serpentina and Protoveratrines A and B Combined)
Trademark



clinically proved combination for moderate or severe hypertension. Each agent appears to potentiate the other's hypotensive activity and produce beneficial vasodilatation, tranquilization, and sedative responses with a minimum of risk.[2] Bottles of 100 and 1000 tablets, each containing 50 mg. *Rauwolfia serpentina* and 0.2 mg. protoveratrines A and B.

Serpate
(Reserpine)
Trademark



presents the principal crystalline alkaloid of rauwolfia...reduces the "psychic magnitude" of everyday stresses in patients with mild or labile hypertension.[3] Bottles of 100, 500, and 1000 scored tablets: 0.1-mg. white, 0.25-mg. yellow, and 1.0-mg. orange tablets.

1. Wilkins, R. W.: Ann. New York Acad. Sc. 59:36, 1954. 2. Meilman, E.: Circulation 13:596, 1956. 3. Wolferth, C. C.: Pennsylvania M. J. 59:327, 1956.

specialists in rauwolfia preparations

VALE

THE VALE CHEMICAL CO., INC.
pharmaceuticals
Allentown Pennsylvania



'ATIENTS IN FAILURE NEED AN ORGANOMERCURIAL

imiting dosage to once daily to avoid refractoriness, or omitting alternate days to ircumvent gastrointestinal irritation—necessary with some diuretics—results in a eesaw of diuresis with fluid reaccumulation and recurrent strain on the already ailing heart.

With the organomercurials, dosage is individualized and administered as needed, o produce sustained, dependable diuresis.

TABLET

NEOHYDRIN

BRAND OF CHLORMERODRIN [illegible]

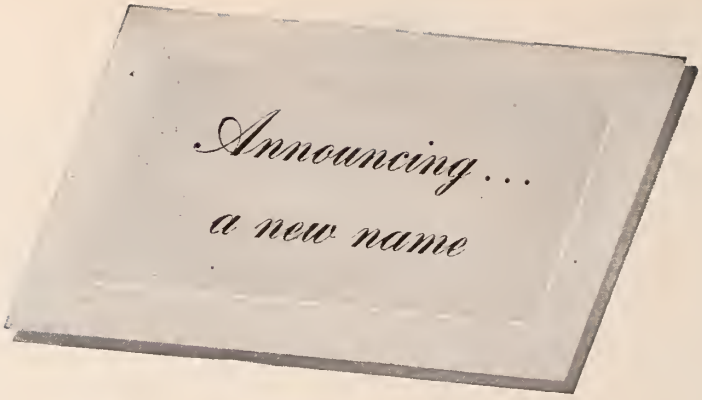
a standard for initial control of severe failure

MERCUHYDRIN® SODIUM

BRAND OF MERALLURIDE INJECTION

LAKESIDE

62556



'LANOXIN'
brand
DIGOXIN

formerly known as Digoxin 'B. W. & Co.'®

The new name has been adopted
to make easier for everyone
the distinction between
Digoxin and Digitoxin.

Now simply write: *'Lanoxin' Tablets 0.25 mg. or 0.5 mg.*
'Lanoxin' Elixir Pediatric, or
'Lanoxin' Injection

to provide the unchanging safety and predictability afforded by the uniform potency, uniform absorption, brief latent period and optimum rate of elimination of this crystalline glycoside.

Tablets:	*0.25 mg. (white) and 0.5 mg. (green)*
Elixir Pediatric:	*0.05 mg. in each cc.*
Ampuls:	*0.5 mg. in 2 cc.*

BURROUGHS WELLCOME & CO. (U.S.A.) INC., *Tuckahoe, New York*

new!
calmative



nostyn®
2-ethylcrotonylurea, AMES

the power of gentleness
for relief of daily tensions

• moderates anxiety and tension
• avoids depression, drowsiness, motor incoordination

different!

.NOSTYN is a new drug, a *calmative*
—not a hypnotic-sedative
—unrelated to any available chemopsychotherapeutic agent
.no evidence of cumulation or habituation
.does not cause diarrhea or gastric hyperacidity
.unusually wide margin of safety—no significant side effects

dosage: 150-300 mg. three or four times daily.

supplied: 300 mg. scored tablets, bottles of 48.

AMES COMPANY, INC • ELKHART, INDIANA

17656

NEW

ATARAXOID is a unique, new combination of STERANE and ATARAX, which now permits simultaneous symptomatic control and reduction of attendant anxiety and apprehension in rheumatoid arthritis and other indications.

The added tranquilizer control, desirably easing mental stress, also directly assists clinical progress. It minimizes the chance of exacerbation related to emotional strain and facilitates patient confidence and cooperation in the therapeutic program toward maximum rehabilitation.

ATARAXOID exerts the anti-rheumatic, anti-inflammatory activity of STERANE distinctly superior to previous steroids, effective in radically reduced dosage, and with minimal disturbance of electrolyte and fluid metabolism.

The ataractic effect is a central neuro-relaxing action – the result of a marked cerebral specificity – free of mental fogging and devoid of any major complications: no liver, blood or brain damage. This peace-of-mind component is also used in the lowest dosage range.

Supplied: Each green, scored, ATARAXOID oral tablet contains 5 mg. prednisolone (STERANE) and 10 mg. hydroxyzine hydrochloride (ATARAX). Bottles of 30 and 100.



PFIZER LABORATORIES
Division, Chas. Pfizer & Co., Inc.
Brooklyn 6, New York

the first and only ataraxic-corticoid

araxoid*

prednisolone and hydroxyzine

Pfizer

combining the newest, safest tranquilizer, ATARAX® + the newest, most effective steroid, STERANE® (prednisolone)

simultaneously controls the symptoms and the apprehension

In Rheumatoid Arthritis, other collagen diseases, bronchial asthma and inflammatory dermatoses

*Trademark

"You try to scrub the bathtub with your back aching morning till night!"

"I don't know about bathtubs, but two days ago I couldn't reach a shelf higher than that."

"I thought maybe I slept in a draft. Never had a stiff neck like this before."

"That's nothing. I went around with my arm in a sling for nearly two weeks– had to sleep with a pillow at my back so I wouldn't roll over on it."

"I thought I was getting too old for high heels– low heels didn't help. My leg hurt down to the ankle."

"Tha
I'm
fee
but
my
bot



... safeguarded relief all the way across

Prednisone + Acetylsalicylic Acid + Aluminum Hydroxide + Ascorbic

Potent corticosteroid anti-inflammatory action complemented by analgesia; doubly protected with antacid and supplemental vitam

"My back was so tight I couldn't even get on and off the bus; now I can climb stairs."

"I hope he helps my knee that quick."

"Take it from me, you should be glad you saw him early in the game so he could do some good."

"Good?— why, he's got me doing exercises I haven't done in years."



read of common rheumatic complaints

Summated, protective corticoid-analgesic therapy

IGMAGEN*

corticoid-analgesic compound tablets

- brings specific, complementary benefits to the treatment of muscle, ligament, tendon, bursa and nerve inflammation
- for the initiation of treatment of milder rheumatic disease
- for continuous or intermittent maintenance in more severe rheumatic involvement

Bottles of 100 and 1000.

Schering

prevents postpartum hemorrhage

speeds uterine involution



'Ergotrate Maleate'

(ERGONOVINE MALEATE, LILLY)

. . . produces rapid and sustained contraction of the postpartum uterus

'Ergotrate Maleate' almost completely eliminates the incidence of postpartum hemorrhage due to uterine atony. Administered during the puerperium, 'Ergotrate Maleate' increases the rate, extent, and regularity of uterine involution; decreases the amount and sanguineous character of the lochia; and decreases puerperal morbidity due to uterine infection.

Supplied:

Ampoules of 0.2 mg. in 1 cc.
Tablets of 0.2 mg.

DOSAGE: Generally, 0.2 to 0.4 mg. I.V. or I.M. immediately following delivery of placenta. Thereafter, 0.2 to 0.4 mg. three or four times daily for two weeks.

80TH ANNIVERSARY 1876 · 1956 / ELI LILLY AND COMPANY

659004

THE JOURNAL

OF

THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

It Can Happen Here

The need to cope with disaster is not a game; it is a living reality. The disaster need not be something as dramatic as an enemy bombing. It can be something as close to us as a major train wreck, a fire in an explosives or chemical plant (and we have many of these in New Jersey), a crash in the skies above us (and New Jersey's skies are heavily freighted with planes) or any other large scale holocaust. And there is no use pretending that a military disaster is a pipe dream either. We are the highway connecting the nation's metropolis with the nation's capital. He who runs may read.

Any hospital in New Jersey may, tomorrow, have to care for 200 or 2000 new patients. May have to evacuate from within its crumbling or burning walls 150 bed-ridden patients. When that time comes will we doctors wring our hands helplessly or will we seize the problem with that sureness of touch which we ought to have?

On page 599 of this JOURNAL is a report by Dr. Betts on the status of disaster planning among our hospitals. There are about 130 hospitals and hospital-like institutions in New Jersey. Only 38 of these have written plans for coping with disaster. The Joint Commission is going to disaccredit hospitals that go through 1957 without preparing a plan. However, an institution should not need that kind of policing to develop a disaster plan. Sheer self-interest as well as a sense of community responsibility should be sufficient. Physicians holding responsible staff positions at the unprepared hospitals now have a chance to take leadership and get something done about disaster planning.

This is no child's chimera. This is not the stuff the dreams are made of. It is the stuff that destruction and death are made of.

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The Social Animal

Back in 1835, DeTocqueville said that "Association is the mother of action. In America, as in no other country has the principle of association been more successfully applied to a multitude of different objects." That was 120 years ago! "In America" he added "societies are formed to resist moral enemies, to diminish vice, to promote order and to advance commerce."

And, indeed, organizations continue to grow and prosper. In a recent publication, *Encyclopedia of American Associations,* (Gale Research Company, Detroit 1956), some five or six thousand *national* organizations are listed. This does not count state, county or city associations; it does not include private or family groups, single PTA's or local Leagues of Women Voters, nor societies which shun listing. If all these are included, the number of associations would certainly exceed 15,000 and might pass 25,000.

We doctors have done our share. One of the most enchanting sidelights to the Gale Company's Encyclopedia is an index of the key words in the names of these societies. If your editor's bifocals do not deceive him, there appear to be at least 270 national organizations in medical or affiliated activities. The parenthetical numeral indicates the number of different nationwide societies with such key words in their titles:

Acoustical (1); alcohol (3); allergy (2); amputation (1); anatomy (1); anesthesia (4); apothecaries (1); arteriosclerosis (1); biometric (1); blood (3); cancer (4); cardiology (1); carbon dioxide therapy (1); chiropodists (1); chronic illness (1); circulation (3); clinical (7); deafness (6); dental (13); dermatology (2); diabetes (1); diagnosis (1); electroencephalography (1); epidemiology (1); epilepsy (2); esophagology (1); fractures (2); gastroenterology (2); geriatrics (2); goiter (1); group therapy (1); gynecology (2); handicapped (2); hearing (3); heart (1); homeopathy (1); hospital (10); hygiene (6); hypnosis (1); joints* (6); laboratory (8); leprosy (3); medical (33); microscopy (1); neoplasms (1); nephrosis (1); nervous (1); neurology (4); nurses (5); obstetrics (1); ophthalmology (3); optical (8); orthodontists (1); orthopedic (5); orthopsychiatry (1); otology (3); paralysis (1); pathology (3); pediatrics (3); pediodontia (1); pelvic (1); pharmaceutical (8); physicians (5); physical therapy (1); psychiatric (5); psychopathology (1); psychosomatic (1); psychotherapy (2); public health (11); radiation (5); rehabilitation (6); rheumatism (1); roentgen (1); Rorschach (1); surgery (17); syphilology (1); therapy (3); thoracic (1); transfusion (1); tuberculosis (2); venereal (1); veterinary medicine (6); and x-rays (2).

This vast multitude of organizations suggests an inefficient and duplicating way of doing business. But it is also a reflection of democracy at work. Sometimes a group within a society feels that its particular field of interest is being neglected by the association's leadership. So they secede and form a new association. Or, they remain within the old organization and also form a new one. This means paying double dues, but thousands of U. S. doctors do just that. It is not uncommon for a medical or surgical specialist to pay dues to three or even four professional societies. This bewildering multiplicity fractionates the strength of the organized specialty, adds to the doctors' dues burdens, and floods his desk with additional journals, news letters and bulletins. But it also gives more members a chance of a year in office or a term as a committee chairman. It is a symbol of the traditional American freedom to form an organization, to "go hire a hall" so to speak. With all its inefficiency, most of us consider the system worth that price.

In America no cause seems to be too odd to warrant an organization. A second glance at the Gale Research Company's list of key words reveals such intriguing organizational groupings as alpine, arboretums, Aztec, blizzard, brassiere and broaching;[1] calendars, chandlers, chop suey and corduroy societies; organizations carry such titles as cremation,

*We cannot tell whether all of these joints are anatomic ones. Some of the organizations so named, might be concerned with machinery, wood-working or night-clubs.—Ed.

dowel, dragon, duodecimal and foremanship; societies for, or of, friction, gagwriters, gemology, goats and gummers; associations devoted to ice cream, ingots, intolerance and jack;[2] leagues interested in kraut, limnology (study of fresh waters), magic, malacology (study of mollusks), monorails, mortgages, mules and mysteries; associations dedicated to negligees, paddles, pests, pickles, pretzels and propagators;[3] organizations concerned with retirement, schiffli,[4] sharecroppers, soybeans, steeplechasing, tapioca and underwear.

This list is real. It is not the product of an editorial nightmare. It's all in the *Encyclopedia of American Associations*. We doctors, thus, are not the worse offenders in the field of specialized organizations. But let the associations continue to gestate! In America, if every man cannot be a king, at least let him be a president. To quote him once more, De Tocqueville, in his distinguished book *Democracy in America*, wrote that "no one can attack the right of association without impairing the foundations of all democratic society."

Regulating Drugs—and Regulating Doctors

One Congressman has already asked for legislation to regulate the prescription and distribution of barbiturates. The motive behind this is an eminently worthy one. Barbiturates should not be disseminated as freely as lollypops, and maybe it is good public health practice to put more obstacles in the way of the easy distribution of these drugs. However, any drug might be toxic. Aspirin, which in many places, is sold as easily as thumb tacks, is potentially dangerous. So is amphetamine. We now have a new battery of nonbarbiturate sedatives and hypnotics, not to mention the tranquilizers. The antibiotics can pack a terrific wallop to the patient as well as to the bug. A careless patient can harm himself with thyroid extract, cough medicine or laxatives.

In many states, at the supermarket check-out counter, you can buy cough drops, throat tickle-easers, purgatives, vitamins and keeper-awakers. While most of these do neither good nor harm, some are potentially hazardous, and it is certainly bad medical practice to hand them out that casually.

But—and here is the big but—should we ask for regulation by law? To regulate you would have to require periodical inventories from all doctors. (Go count every barbiturate capsule in that back closet now). You would have to write in the name, age, diagnosis and address of each patient. You would have to keep lists in duplicate and be prepared to show them to inquiring G-men or T-men. You might even (remember prohibition, and *spiritus frumenti?*) have to justify to a lay inspector why you prescribe so many barbiturates or so much amphetamine. If you want to regulate the dissemination of these drugs, you can probably get the regulation all right.

But *you* would have to be regulated too. Where can we stop? If barbiturates are regulated, why not aspirin? If amphetamine, why not cough drops? If you need a special ℞ form for reserpine, why not one for chlorophyll throat lozenges?

Do we really want more regulation of daily practice?

1. We can't figure this one either. Our dictionary says that "to broach" is to stab, pierce, spit, spar, drift, enlarge, dress, violate, deflower, utter or to come to the surface. And a broach is a tool for making non-round holes. What a National Broaching Association or League of Broachers does, we do not know. But we fight to the death for their right to do it.
2. A Society of, for, or against jacks is what? The same dictionary says that jack can mean any male, except in electricity when a jack is "a female terminal." Also, it says, jack can mean a sailor, a bootjack, a sawhorse, a pump, winch, small lift, or a knave in cards. And, vulgarly, jack might mean money.
3. This is not what you think. A propagator is a gardener who raises plants in a nursery.
4. Schiffli is a power machine for spinning rayon.

Robert L. Breckenridge, M.D.

Camden

Tissue Reactions to Mycotic Infections*

Fungus infections vary in their presenting cellular reactions. A granulomatous reaction is the commonest. Diagnosis is easy enough if the responsible organism can be found. If it isn't found, what then?

Observations on fungus infections show many differences in their cellular reactions.[1] They vary from an acute process with or without suppuration to chronic inflammation and to a stage of repair with macrophages, giant cells, plasma cells and fibrosis. By themselves, these reactions may give little or no clue as to the etiology. In most cases, however, the histologic changes are chronic, more specifically a granulomatous reaction, which alerts us to the possibility of a mycotic vector. The granuloma may be a tubercle with caseous necrosis and giant cells not unlike tuberculosis. Or it may be in the form of macrophages, epithelioid cells, plasma cells, lymphocytes, and eosinophils. Sometimes the microscopic changes are subtle and only an occasional macrophage or a single giant cell offers the necessary clue to suggest further search for the fungus by examining more sections, using special stains, and elaborating further on the clinical record. The diagnosis becomes simplified and usually specific on finding the organism itself. It occurs as mycelia in the tissue spaces or as a doubly refractile spherule which may be present within monocytes, giant cells, or free in the tissues.

In man, there are three general types of fungus infections: the systemic, intermediate and superficial mycoses. *Systemic* mycoses are those fungus infections that involve the internal organs and systems. They include coccidioidomycosis, histoplasmosis, blastomycosis, cryptococcosis, actinomycosis, nocardiosis, South American blastomycosis, mucormycosis, aspergillosis, and geotrichosis.

Intermediate mycoses are those infections generally confined to the skin, subcutaneous tissues and mucous membranes; they may become systemic. Moniliasis and sporotrichosis are the best examples. Maduromycosis, chromoblastomycosis, rhinosporidiosis and some cases of Trichophyton rubrum may also belong here.

Fungus infections limited to the hair, skin and nails are called the *superficial* mycoses or dermatophytoses.

Since the superficial mycoses produce little or no tissue reaction, this discussion will be limited to the more important systemic and intermediate mycoses.

Coccidioidomycosis

Coccidioidomycosis occurs as a primary pulmonary disease and only rarely as a disseminated one. Sixty per cent of the cases of the

*Presented before the Section on Clinical Pathology, Annual Meeting of The Medical Society of New Jersey, May 15, 1956. The author is Director of Laboratories at Our Lady of Lourdes Hospital in Camden.

1. Baker, R. D.: *Histopathology of the Mycoses.* Washington, D. C., 1945 AFIP

pulmonary form are asymptomatic and are diagnosed mainly by skin testing. The others occur in various non-specific pulmonary infections.[2] Cavities develop in less than 10 per cent of these cases, usually within a week or two after the onset. Nodules or irregular densities with occasional calcification may develop in a few weeks or months.[3] These may persist for years and are the most common types seen outside the endemic areas. Significantly *no case with a residual pulmonary cavity has ever been known to disseminate.* Most of the cavities are single, located in the upper chest and are often associated with nodular foci. Less often there is hilar lymph node enlargement, miliary lung involvement, pleural effusion, and persistent pneumonitis.[4]

The commonly involved organs with dissemination are the skin, subcutaneous tissue, viscera, and bone. The histologic character of the inflammatory reaction varies considerably in any one lesion, and also varies from lesion to lesion in the same individual depending upon the number and developmental stage of the organisms present. Suppuration is common in the presence of free endospores, and macrophages and giant cells appear as the spores become mature.

The tubercles differ from those in tuberculosis by the presence of numerous leukocytes and only a few epithelioid cells and multinucleated giant cells. A varying amount of fibrosis occurs around the foci of inflammation. The organisms are usually found in large numbers within the abscesses and tubercles.[5] They may be free in the tissues or within giant cells. In the tissues they appear as non-budding, round, thick-walled structures measuring from 20 to 80 micra. Since the immature cells may contain only a few endospores, they may be confused with non-budding forms of *Blastomyces.*

HISTOPLASMOSIS

One of the outstanding advances in medicine during the last decade was the discovery of the common benign forms of histoplasmosis. The traditional course of histoplasmosis with its widespread involvement of the reticuloendothelial system is rare.

Histoplasmosis can be classified[6] as *pulmonary* (either asymptomatic or symptomatic) *disseminated,* (either nonfatal or fatal) and *localized* (tongue, larynx, skin, or penis).

The *asymptomatic* form is based on the finding of pulmonary calcifications in a tuberculin negative and histoplasmin positive individual. The calcifications resemble those found in tuberculosis. In most cases of the symptomatic pulmonary type the disease appears as a disseminated pneumonitis resembling tuberculosis. On x-ray, the lesions vary from fine, mottled, granular infiltrations to soft, miliary nodules. They have a marked tendency to calcify after four or five years.

Disseminated histoplasmosis frequently occurs purely as a cytomycosis; the organisms having been phagocytosed by the cells of the reticuloendothelial system, particularly in the liver, spleen, lymph nodes, and bone marrow. It is like a storage disease rather than an inflammatory process. The yeast phase of the fungus is present mainly in the cytoplasm of the reticuloendothelial phagocytes.

Routine histologic examination may fail to demonstrate the small intracellular yeast organisms. If the doctor suspects the possibility of the disease, the Hotchkiss-McManus stain, as in other fungus infections, will frequently make the yeast visible. Histoplasma capsulatum is very small, simple or budding, oval or round, yeast-like cell measuring one to four microns, and having a thick, clear, colorless capsule. The budding forms are rare in tissues.

Histoplasmosis resembles kala-azar not only clinically but also pathologically.[5] Histoplasma capsulatum is slightly larger, has a more prominent nucleus, and lacks the kinetoplast and parabasal body of Leishmania. Since the tissue

2. Smith, C. E.: Diagnosis of Pulmonary Coccidioidal Infections. California Med. 75:385 (1951)

3. Smith, C. E., Beard, R. R. and Saito, M. T.: Pathogenesis of Coccidioidomycosis. Ann. Int. Med. 29:623 (1948)

4. Jamison, H. W.: Roentgen Study of Chronic Pulmonary Coccidioidomycosis. Am. J. Roentgenol. 55:396 (1946)

5. Ash, J. E. and Spitz, S.: *Pathology of Tropical Diseases.* W. B. Saunders Co., Phila., 1945.

6. Jillson, O. F.: Medical Progress: Mycology, New England J. Med. 249:523 (1951)

reaction is identical in the two diseases, cultures may be required to differentiate them. Otherwise we may have to rely on their different geographical distributions.

NORTH AMERICAN BLASTOMYCOSIS

North American blastomycosis is a chronic infection caused by Blastomyces dermatitidis. The disease may be classified as cutaneous, pulmonic, or systemic. Except for a few isolated cases, this infection has been limited to the United States, mainly in farmers. The human infection probably spreads from animal forms of the disease.

The *cutaneous* lesions occur mainly on the exposed parts of the body. The representative lesion is an indolent papule that develops slowly over a period of months to years to form a verrucous growth. Satellite papules may appear. The overlying epidermis forms a pronounced pseudoepitheliomatous hyperplasia that may be mistaken for a squamous cell carcinoma. Miliary intradermal abscesses characteristically form the bulk of the papule. The abscesses are composed of leukocytes, desquamated epithelium, and the blastomycetes. A diffuse inflammatory reaction with small granulomas resembling tubercles surround the abscess.

The *pulmonary* lesions vary from small to large caseous nodules and abscesses. Although pulmonary cavitation is infrequent it can occur.

The *disseminated* form can follow either the cutaneous, or, more frequently, the pulmonary form. The skeletal system is usually involved and cutaneous sinuses may develop over the involved bone. This can be confused with tuberculous osteomyelitis.

Usually there is considerable difficulty finding the organism in the tissues. They are round or oval with a homogeneous, thick-walled, doubly refractile capsule. Budding is a distinctive feature that is helpful in differentiating it from Coccidioides immitis. When the bud is about half the size of the mother cell, it breaks off. For this reason it is not unusual to find the organisms in pairs with one of the pair being smaller than the other. The disseminated lesions are histologically similar to the cutaneous ones. Large numbers of organisms are frequently present in the abscess but the majority of them are dead. Well preserved organisms are best seen within the giant cells.

CRYPTOCOCCOSIS

Cryptococcosis, European blastomycosis, or torulosis is a chronic infection caused by Cryptococcus neoformans (Torula histolytica) and mainly involves the meninges. The disease is especially prevalent in Europe but is found in North and South America. It occurs mainly in adults, but, when calcifications of the brain are found by roentgenologic studies of newborns, cryptococcosis must be considered as well as toxoplasmosis.[7]

Convincing evidence [8] is accumulating that a pulmonary infection precedes the meningitis and that benign and asymptomatic forms occur as in coccidioidomycosis and histoplasmosis.

In the meninges, suppuration is absent and the organisms may remain a long time without stimulating an inflammatory response. The organisms are accompanied by an accumulation of a mucoid material frequently in the form of cysts. The cysts occur to a lesser degree in the visceral lesions. There are usually a few plasma cells, lymphocytes, monocytes and numerous organisms. The latter are oval or round, budding cells with a thick wall surrounded by a wide, clear capsule. The cells stain a dark brownish-red with hematoxylin. Non-suppurative granulomas may be found in chronic cases.

Concomitant association of Hodgkins disease and chronic cryptococcosis is more frequent then would occur by chance.[9] This may result from a malignant degeneration of infected lymph nodes;[8] be a mistaken diagnosis, since the granulomatous lesions in cryptococcus lymphadenitis resemble Hodgkins disease

7. Neuhauser, E. B. D. and Tucker, A.: Roentgen Changes Produced by Diffuse Torulosis in Newborn. Am. J. Roentgenol. 59:805 (1948)

8. Cox, L. B. and Tolhurst, J. C.: *Human Torulosis*, Melbourne, Melbourne Univ. Press, 1946.

9. Gendel, B. R., Ende, M., and Norman, D. L.: Cryptococcosis, Am. J. Med. 9:343 (1949)

or be the result of impaired immunologic response in the presence of Hodgkins disease.[6] There is no proof that Cryptococcus neoformans can cause a lymphoma.

ACTINOMYCOSIS

Actinomycosis is one of the most common and best known of the systemic mycoses. It is an acute or chronic granuloma produced by various species of Actinomyces. The disease is world-wide especially in agrarian areas. The common clinical forms are cervicofacial, thoracic, and abdominal. In the first group the infection frequently begins in the area of an infected tooth. The face or neck become swollen and multiple sinuses develop. A series of persistent sinuses and fistulae is characteristic of actinomycosis. The cervicofacial forms usually remain localized but may metastasize to other organs, particularly the lung. The thoracic and abdominal forms, however, are more often primary. The common organs other than the skin are the lungs, tongue, intestines, bones, and brain. The visceral forms are invariably fatal whereas the cutaneous ones are seldom.

The histologic appearance, in any form, consists of abscesses with some suggestions of a granuloma. The central part of the lesion usually contains the actinomycotic granules surrounded by purulent debris. A zone of granulation tissue containing lipoid-filled phagocytes is next, and a wall of leukocytes, plasma cells, and fibroblasts completes the abscess.

Actinomyces bovis, the typical ray fungus, is gram-positive, non-acid-fast, and is composed of masses of branching mycelial threads, centrally tangled but radially arranged at the perimeter. The latter may or may not be clubbed.

When the disease is caused by Nocardia asteroides, one of the aerobic forms, the fungus may not be demonstrated with the usual hematoxylin and eosin stains. In tissues the fungal filaments are scattered and not aggregated into a "ray." The organisms are gram-positive, sometimes acid-fast, branching mycelial filaments within the granulation tissue.[6]

MONILIASIS

Monilial infections are caused by Candida (Monilia) albicans. Besides the superficial mycoses, the infections include oropharyngitis, bronchopneumonia, endocarditis, and meningitis. The incidence of these systemic diseases has increased with the widespread use of antibiotics. Since the antibiotics do not stimulate the growth of the organisms, it is believed that they grow rapidly once the normal inhibiting bacterial flora are destroyed.[6]

The bronchopulmonary form is also secondary to a previous pulmonary infection such as pneumonia or influenza. The fungus produces a granulomatous reaction without necrosis. Solid tubercles composed of epithelioid cells, monocytes, plasma cells and a few neutrophiles are common.

SUMMARY

There are many differences in the cellular reactions of all types of fungus infections, varying from an acute process with suppuration to chronic inflammation and repair. In most instances, however, the reaction is granulomatous in nature, suggesting the possibility of a mycotic disease. Finding the organism is usually diagnostic. Examination of smears, cultures from man and inoculated animals are often necessary for final identification of the causative organism.

Fungus infections in man are of three general types; systemic, intermediate, and superficial mycoses. The more important of the systemic and intermediate forms are discussed in detail.

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Acute Appendicitis in Situs Inversus*

Report of a Case

If the appendix is on the left side, would the patient feel appendiceal pain in the left iliac fossa? No—he would still feel pain on the right side. Why? Read on and find out.

Situs inversus is a relatively rare phenomenon that causes no harm to the patient.[1] However, in the presence of a surgical abdomen the patient with situs inversus may end up with two incisions. Probably the first cases observed were two by Aristotle.[1] In 1600 A.D. Fabricius described a case of reversed liver and spleen, and in 1615 Petrius Servius, in Rome, recorded a case of transposition of the viscera.[2] The first authentic cases were reported at the time of Moliere,[3] among which was Maria of Medici, Queen of France. In 1824 Kuchenmeister[1] first recognized the condition in a living person and in 1897 Vehsemeyer[1] first demonstrated this anomaly by use of x-ray.

According to Blegen[4] the incidence of situs inversus in patients examined clinically is one in 6,587 and in those examined at autopsy, it is one in 6,164. It is twice as common in men as in women. Blegen[4] reports 99 cases of appendicitis in situs inversus up to 1949. Of these only 39 were diagnosed before operation. Since then, Abel[5] and Winter,[6] have each reported a single case. Both were diagnosed prior to surgery.

*From the Surgical Service of Dr. William Crecca, at the Martland Medical Center, Newark, N. J. Dr. Jules was the Chief Surgical Resident at that hospital.

CAUSE

The embryologic factors which determine whether an individual will have the usual arrangement of viscera or its mirror image are unknown. Situs inversus has been experimentally produced by Pressler and Spemann on a bombinator.[10] Speeman removed a portion of the medulla together with a portion of the roof of the primitive gut in the neurala stage and reversed its position. Many of the tadpoles resulting from this experiment showed complete situs inversus viscerum.[10] Summer and Heustis[8] conclude from their studies on insects that the anomaly is probably due to a recessive gene. Cockyne[11] said that he demonstrated a genetic process which he believed to be a recessive gene lying in the X chromosome. This, he suggests is responsible for the reversal of the viscera.

Situs inversus viscerum should not be confused with any abnormal form of rotation. At the end of the fifth week of intra-uterine life, the abdominal portion of the intestinal tract is divided into three parts, according to form and blood supply—the foregut forming the upper loop supplied by the celiac axis, the midgut forming the umbilical loop supplied

by the superior mesenteric artery and the hindgut or lower loop supplied by the inferior mesenteric artery. Because of the rapid growth of both the liver and the midgut, there is little available intra-abdominal space so that about the eighth week of intra-uterine life, most of the midgut lies outside of the abdomen as a physiologic umbilical hernia. At an early period, the lower end of the foregut and the upper end of the hindgut become fixed from which the midgut loop is suspended. At about the tenth week, the midgut begins to return to the abdominal cavity rotating 270 degrees counterclockwise about the axis of the superior mesenteric artery from the sagital position of the primitive umbilical loop. Rotation is complete by the eleventh week [12] and the cecum has reached the right loin. In non-rotation or failure of rotation of the midgut loop, the small intestines lie to the right of the midline and the colon to the left. This is a result of the coils returning from the umbilical cord to the abdominal cavity en masse and retaining their primitive arrangement. In malrotation of the midgut loop there are irregular defects of rotation and fixation. In reversed rotation there is a 90 degree clockwise rotation instead of the normal 270 counterclockwise one. Thus, the transverse colon passes dorsally to the duodenum and superior mesenteric artery.

CASE REPORT

A 16-year old girl was admitted to the Martland Medical Center complaining of right lower quadrant pain, accompanied with nausea and vomiting beginning the evening prior to admission. Bowel movements were normal. There were no urinary symptoms. Except for a slight cough, she had no respiratory complaints. Menstrual periods were normal. The last period ended two weeks before admission. Her past history was essentially normal.

She was a well-developed but undernourished girl who appeared to be acutely ill. The abdomen was flat and soft. She had pain and direct rebound tenderness in the right lower quadrant. *There was also pain on palpation in the left lower quadrant.* The psoas sign was positive on the right side. In rectal examination, the patient was more tender on the right than on the left side.

Temperature was 100 and pulse 85. Blood pressure was 110/80. Blood count was normal as was the differential leukocyte count. Sedimentation rate was seven millimeters per hour.

Because of the clinical findings, a diagnosis of acute appendicitis was made and the patient taken to surgery. The abdomen was entered through a right McBurney incision but the cecum could not be found. The incision was extended enough to allow for further exploration and the appendix was felt on the left side. This incision was then closed and a left McBurney incision was made. An acutely inflamed appendix, in the lumen of which was a "hard stone," was removed from a cecum located in the left iliac fossa. The patient made an uneventful recovery.

After full recovery, a series of x-rays and an electrocardiogram were taken. X-rays of the chest, gall bladder, a gastro-intestinal series and a barium enema showed a complete transposition of her viscera. The electrocardiogram revealed an inversion of all deflections in Lead 1 with the characteristic changes of dextrocardia in the augmented unipolar limb leads and in both levo and dextro precordial electrocardiograms. This patient was an example of complete situs inversus.

VISCERAL PAIN PERCEPTION

IN THOSE cases reviewed by Blegen,[4] the point of maximum pain was in the left lower quadrant in 32 cases, in the right lower quadrant in 21, and throughout the lower abdomen in four. In both Abel's [5] and Winter's [6] cases, the point of maximum pain was in the *left* lower quadrant.

In visceral disease, "referred pain" is localized in the somatic area which is supplied by nerves connected with the same segments of the central nervous system as those supplying the viscus.

In the normal individual, appendiceal pain usually occurs above the umbilicus early in the disease and later localizes over McBurney's point. Epigastric pain, nausea, vomiting, right lower quadrant pain, and rigidity can occur with dilatation of the appendix without any involvement of the parietes.[15] Therefore in the disease, cases of appendicitis in transposition of the viscera referred phenomena ought to be localized on the right side. Even though the viscera are transposed, their nerve supply remains the same.[14] Later when the inflammation has involved the peritoneum (somatic perception), pain is felt directly over this area.

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A list of 15 citations appears in Dr. Jules' reprints.

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Epidemiologic Aspects of Infectious Diseases*

Epidemiology is not a slide-rule and paper art practiced by some statistician under the State House dome. It is, rather, an unconscious component in every doctor's daily practice. Accident-prevention and diabetes, tuberculosis and gonorrhea, industrial diseases and poliomyelitis are just a few of the many medical problems to which epidemiology can make a contribution.

Although the most notable contributions to our epidemiologic knowledge have come from the study of infectious diseases, we need to recognize the value of epidemiologic studies of heart disease, arteriosclerosis, cancer, nephritis, diabetes, and other non-infective conditions, in which epidemics are not characteristic but in which the disability, misery, and economic losses are enormous.

The task of the practical epidemiologist is to search for the factors which favor the transmission of infection such as polluted water or milk, flies, and mosquitoes, and to direct the attack against the weakest link through which control can be attained, such as the purification of water, pasteurization of milk, and elimination of flies and mosquitoes. The evidence submitted by the epidemiologist may on the other hand suggest that it is best to strengthen the resistance of the host through specific immunization, improved nutrition or personal hygiene.

In every epidemiologic investigation, whether to explain the occurrence of an infectious or non-infectious disease, the objective is a better understanding of the nature of a disease and the establishment of associations with particular conditions which may have led to its occurrence. The practical epidemiologist studies all possible factors and evaluates their relative importance. This implies an orderly assembly of information and a piecing together of evidence from which to formulate a theory which can be supported by laboratory and other data. Not infrequently this process requires an equal portion of science and common sense.

Lest you gain the impression that epidemiologic studies require access to many cases, let me remind you that even in its simplest form the individual case involves a group—a family.

COMMUNICABLE DISEASE CONTROL

In the revision of the State Sanitary Code promulgated by the Public Health Council in June 1953 important changes were made in the chapter dealing with the control of communicable diseases. Thus, chicken pox, German measles, and mumps were omitted from

*This paper was read, by invitation, to the Pediatrics Section of the Annual Meeting of The Medical Society of New Jersey in Atlantic City on May 16, 1956. Dr. Weigele is Director of the Division of Preventable Diseases in our State Health Department.

the list of reportable diseases. Immunity is acquired only by *having* these diseases and it does not appear desirable to avoid early natural exposure. Chickenpox in an adult may be severe. Orchitis in mumps is rarely observed before puberty but it occurs in about one-fourth of the adult males. The observation of congenital defects in the offspring of women developing German measles during the first trimester of pregnancy is a good reason why young girls should acquire this disease.

Isolation and quarantine regulations were modified to permit the restrictions to resemble a filter or sieve. The art consists in regulating the openings in the quarantine filter or sieve to hold back only certain exposed persons.

Carriers are the chief source of new typhoid cases in otherwise well protected communities. Most persons convalescing from typhoid become free of the organisms within three months after the termination of their disease. But, two to four per cent continue to discharge typhoid organisms indefinitely. Realizing the need for more energetic search for carriers among persons recovering from typhoid, the Sanitary Code regulation was revised to require the collection of four stool specimens at intervals of not less than three months apart beginning ninety days after clinical recovery.

TUBERCULOSIS CONTROL

THE accomplishments in the control of tuberculosis are not mere coincidence but rather the continued application of epidemiologic methods. These methods involve among others:

1. Recognition and reporting of all cases of tuberculosis.

2. Reporting of a change in status from inactive to active.

3. Follow-up of contacts of active cases.

4. Follow-up of contacts of patients who have died.

5. Follow-up of contacts of children with positive tuberculin reactions.

Any program to find unknown cases of tuberculosis has value only if it sets in motion procedures by which suspected cases are discovered, diagnosed, and treated. Undiscovered tuberculosis may progress to a stage of hopeless intractability at the same time adding other links in the chain of infections.

The vast potentialities of the fundamental epidemiologic tools of case finding and case control have not been realized because we still have reported in each of the last three years more than 2,000 active cases of tuberculosis in New Jersey. Of the 558 deaths from tuberculosis in 1955, more than 200 were reported as tuberculosis during the month of death, after death, or not reported at all. How much more effective would have been the prevention of new cases of tuberculosis had the illnesses which caused the 200 deaths been reported earlier and had the search for contacts been done earlier!

POLIOMYELITIS IDENTIFICATION

THE interrelations and overlapping clinical features of poliomyelitis and other diseases form a group of intriguing problems. A variety of infections such as lymphocytic choriomeningitis, mumps meningitis, herpes simplex, infection with Coxsackie viruses, eastern and western encephalitis may simulate poliomyelitis. Errors in diagnosis lead to errors in reporting, which in turn may falsely discredit the vaccine.

Epidemiologic and laboratory studies will be made in this and succeeding years of reported cases of poliomyelitis in children who have received Salk vaccine. If the interval from vaccination to the onset of poliomyelitis is 30 days or less, the question of safety and effectiveness of a particular lot of vaccine must be considered, especially if there is correlation between the site of injection and site of first paralysis.

VENEREAL DISEASE EPIDEMIOLOGY

VENEREAL diseases are not so widespread as they were ten years ago. But there are still many scattered areas of high incidence and prevalence. These areas, if not identified and controlled, will be foci of infection from which an increase in overall rates will stem.

The venereal disease control problem is unique. We have no agent for immunizing the population; we cannot isolate the host because we cannot always find him. We cannot eliminate the intermediate host because there is none. Thus the principal control effort is directed toward finding cases among the sex contacts of infected people and bringing these individuals to examination and treatment. Additional cases can be found by serologic tests by physicians in private and hospital practices and by blood test surveys of suspected high prevalence groups. In New Jersey, we have surveyed urban and rural populations, industrial, and itinerant groups with a yield in reactors in the 10 to 15 per cent range. The migrant labor group consistently produces well over 20 per cent reactors.

In 1955, physicians in private practice reported 45 per cent of the cases of syphilis and 30 per cent of the cases of gonorrhoea reported to the State Department of Health. With the likelihood of continued shift in venereal disease control to private physicians, epidemiologic investigation of their patients takes on additional importance. Successful interview of the venereal disease patient for sex contacts requires special approaches and technics. An increasing number of cases could be brought under examination and treatment if physicians would use the competent interview service available through their local or district health officer.

ANIMAL DISEASES

YOUR State Department of Health has an advisory committee of physicians and veterinarians who periodically meet to discuss the various animal diseases transmissible to man. In addition the Department has an epidemiologic team consisting of a veterinarian, a laboratory worker, and a physician. This team keeps itself informed of all currently prevalent diseases and is available to help medical, dental and veterinary practitioners with diagnostic and epidemiologic services.

Typical of this latter activity was the participation of members of the team in an outbreak of psittacosis (ornithosis) among several thousand turkeys on a farm in central New Jersey. The infection was traced to eggs obtained from farms in Oregon, California, and Texas. The farm in Oregon (to which suspicion pointed one year ago) has recently had more than sixty cases of psittacosis and two deaths among the workers. Another contribution of the epidemiologic approach in this disease has resulted in making a diagnosis in many instances by isolation of the virus and serologic studies on human beings and birds. In cooperation with local veterinarians treatment procedures were developed and perfected that have avoided the former practice of killing all infected birds.

In our rabies control program, we may point with pride to the two cases reported in the past three years as compared to 232 cases of rabies in Pennsylvania and 1426 cases in New York in the same period of time. The good results in New Jersey have been accomplished by local programs of dog control, elimination of strays, and vaccination. Epidemiologic evidence supports the reduction of wildlife reservoirs and periodically a trapping of animals, particularly foxes, is carried out in a ten mile wide strip along the northern border adjacent to New York.

Your State Health Department, in cooperation with Yale University, is presently conducting research studies of toxoplasmosis in raw garbage-fed hogs and the possible infection of slaughter house workers and others to whom the disease may be spread from swine, dogs, and cats. Again, your State Health Department, in cooperation with the Division of Fish and Game, Rutgers University, and the United States Public Health Service has been studying the basic facts of the transmis-

sion of the various encephalitides. One of the first isolations of western equine virus in this part of the country was made in the course of this study which is still in progress.

DIABETES

EPIDEMIOLOGIC studies have established the following:

1. Predisposition to diabetes is a hereditary trait.
2. Overweight tendencies among relatives of diabetics should be avoided.
3. Diabetes becomes a progressively more serious threat as the years advance.

By informing diabetic patients that the disease tends to run in families (even though this does not prevent marriage between diabetics), the physician places his patients on guard for the early symptoms of the disease in their children. The diabetic pays a heavy penalty for being overweight. By correcting overweight tendencies among members of the diabetic family the physician helps prevent new cases.

By emphasizing the importance of periodic medical examinations of persons over forty years of age the physician can detect the insidious onset of diabetes and other chronic illnesses. Diabetes is a serious disease that can be discovered easily and inexpensively. The principal problem in the control of diabetes is the application of detection methods that will reach the million or more persons who do not know they have diabetes and bring them under medical supervision before their disease becomes advanced and irreparable damage is done.

MULTIPHASIC SCREENING

MASS screening surveys for epidemiologic study of diseases have been conducted for many years. For the most part, these surveys have been aimed at a single disease such as diabetes, tuberculosis, or syphilis. Successful as some of these detection drives have been, the one-at-a-time practice is gradually giving way to the multiphasic approach.

The best way to detect disease in its earliest stages is for the doctor to practice detection in his own office. However, many people have no concept of preventive medicine and do not seek advice when well. The only practical way of locating a reasonably high proportion of potentially crippling conditions in their early stages is by screening many presumptively well persons and finding those who need to be referred to physicians for definitive diagnosis and care.

RADIOLOGIC HEALTH

ONE of the newer problems confronting health departments concerns not only those exposed to sources of ionizing radiation in industry but also the users of such devices as x-ray machines, radioisotopes, and fluoroscopic shoe-fitting machines all of which increase the radiation exposure and make necessary education in safe handling and varying degrees of regulation and control.

The moment one inquires about the characteristics of a disease, the conditions and circumstances of its occurrence, and compiles the data to make information available to others, consciously or unconsciously epidemiologic principles are being applied. Thus, the study of diseases resulting from exposure to sources of ionizing radiation requires information from the aspects of the agent, host and environment. We must identify the agent capable of causing the reaction or the clinical picture the agent produces in the host.

We need to study the environment around known foci of exposure in order to set up effective barriers to prevent contact between the agent and the host such as shielding, protective clothing, adequate ventilation, and proper disposal of radioactive wastes.

The epidemiologist can find many opportunities in industry to collect observations, to determine the importance of various relationships in the environment to the development of disease, and to conclude how the deleterious effects of certain industrial products or practices can be avoided.

ACCIDENT PREVENTION

ACCIDENTS and accidental poisonings are the leading cause of death in this country in children over 1 year of age. Injuries follow some of the same biologic laws as do disease processes. They are responsive to the same epidemiologic approach. Accidents attack and impair bodily health. The cause of many can be determined. Many are preventable. In gathering the necessary information there is no fundamental difference between determining the cause of accidents and the cause of typhoid fever. In either case one needs to study the interaction between the agent, host, and environment to develop control measures.

CONCLUSIONS

1. Epidemiology is a discipline applicable to all diseases that affect groups of people and restriction to the communicable diseases is no longer justified.

2. Epidemiology can define health problems in the field of non-infective diseases and can guide programs for their control.

3. Many problems of preventive medicine await only the application of epidemiologic methods. They will best be solved when those most concerned with the health of individuals and with the health of the community as a whole coordinate their efforts for the tasks that need to be done.

The State House

Do Catalysts Hold the Key to Aging?

Catalysts in the human body hold the key to both cancer and the deterioration of aging, Eugene J. Houdry, dean of catalytic scientists, told the Congress on Catalysis at its 1956 convention. Dr. Houdry said that oxidation enzymes are vital elements in the normal chemistry of life. They promote transformation of food into body energy. Dr. Houdry said there is a remarkable similarity between organic enzymes and their inorganic counterparts, the industrial oxidation catalysts. He suggested that the effects of aging could be retarded by increasing the oxygen intake of the human machine. A solution to the cancer problem by regeneration or replacement of the wayward enzymes should not be too far off. These technics (increasing oxygen regeneration or replacement of units) are standard for prolonging the life of the industrial catalyst or restoring it to working order.

"We learned that the living cancer cell results from a catalytic change in the enzymes of a normal cell," he said in speaking of these early days. This led him to study further the working of the human body, the supreme catalytic machine.

Bodily functions stem from the oxidation of food and in this process the oxidation enzymes are the vital factor. During the first 20 years of the life span, oxidation of food is so controlled as to insure a decreasing rate of growth of the human machine, Dr. Houdry said.

"Thereafter the phenomenon of oxidation through enzymes is the most important thing in the chemistry of life, and a comprehension of what might be done with the body as a machine comes within the realm of our thinking," he added.

In speaking of the "great menace that air pollution is to mankind," Dr. Houdry said that "catalysis will provide us with the most practical tools to help win this fight."

By 1965, Dr. Houdry predicted, if enzymes really were related to inorganic oxidation catalysts, something more important than cleaning the air could be done for human life.

On the cancer front, Dr. Houdry cited the discovery—"probably the greatest in cancer research"—by Dr. Otto Warburg that a cancer cell obtains energy about equally from fermentation and respiration whereas a normal cell obtains most of its energy from respiration.

This indicates a fundamental change in the enzyme reaction.

"There is the catalytic problem . . . and to solve it by regeneration and replacement should not take too long."

David B. Scanlan, M.D.

Ventnor

Aortic Aneurysm Simulating Renal Colic*

Report of Three Cases

Deaths are always poignant experiences for the attending physician. There is a double poignancy about the death when the doctor had made a diagnosis of renal colic or some other usually benign condition. Dr. Scanlan here reviews cases of ruptured aortic aneurysm masquerading as renal colic.

The diagnosis of abdominal aneurysm is often difficult. Bryant [1] in 1903 in a review of a half century of experience at Guy's Hospital stated that diagnoses were made in only one third of the cases. In 1956, Enselberg,[2] in a review of 37 cases of abdominal aortic aneurysm and Baer [3] in a review of 86 cases of dissecting aneurysm state that the diagnoses were made in less than 50 per cent of instances. Erroneous diagnoses have implicated practically every organ or structure below the diaphragm. The urinary system was incriminated eight times in one series of 86 cases [3] and seven times in another series of 37 cases.[2] Patients with abdominal aneurysm have been operated on with a preoperative diagnosis of acute appendicitis,[4] calcified retroperitoneal tumor,[5] perinephritic abscess,[6,7] renal colic,[2,8,9] cholethiasis [2] and ectopic pregnancy.[2]

This report is the result of my having seen in consultation three cases with a provisional diagnosis of renal colic. *All three were finally proved to be ruptured abdominal aortic aneurysm.*

CASE ONE

A 62-year old man was referred for x-ray study because of pain in the left upper quadrant. Fluoroscopy of the gastro-intestinal tract and chest, x-ray studies of the lumbar spine, and a gastro-intestinal x-ray series were all negative, except for calcification of the abdominal aorta. An orthopedic consultant made a diagnosis of a left renal colic. Cystoscopy and retrograde pyelograms were performed. Examination of the bladder and posterior urethra was negative. Indigo-carmine appeared from the right ureteral orifice in 15 minutes in moderate concentration. No indigo-carmine was visualized from the left ureteral orifice in 20 minutes. There was no drainage from the left ureteral catheter. X-ray study showed motion of the left ureteral catheter which was interpreted as the result of a transmitted impulse. There was obliteration of the left psoas outline. A soft tissue mass in the left upper quadrant was visualized. A calcific plaque earlier visualized was no longer seen. The left retrograde pyelogram showed cephalic dis-

*Presented by invitation before the Philadelphia Urologic Society, May 27, 1956.

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3. Baer, S.: Journal of the American Medical Association, 161:689 (1956).

4. Karabin, J. E.: American Surgeon, 18:2 (1952).

5. Lazarus, J. A. and Marks, M. S.: Journal of Urology, 52:115 (1944).

6. Davis, R. L.: Journal of Urology, 41:332 (1939).

7. Rusche, C. and Bacon, S. K.: British Journal of Urology, 7:330 (1935).

8. Willis, P. W.: Surgical Clinics of No. America, 10:1231 (1930).

9. Carlson, H. E.: Southern Medical Journal, 38:607 (1945).

placement of the kidney for a distance of 5.6 centimeters. Blood urea nitrogen was 31. There was a leukocytosis of 18,400. At surgical consultation, a provisional diagnosis of perinephritic abscess involving the lower pole of the left kidney was made. The left kidney was explored and a ruptured abdominal aortic aneurysm was demonstrated. The patient died at the time of operation.

CASE TWO

A 67-year old physician was hospitalized with a complaint of pain originating in the right lumbar area and radiating to the right upper quadrant. The pain had been present for 4 days. On admission he vomited coffee-brown material. Blood pressure was 100/60 and the temperature was 100. There was a leukocytosis of 22,000. The urine contained 40 pus cells per high power field. Provisional diagnosis was right pyelonephritis, or right perinephritic abscess. Intravenous urogram showed a soft tissue density 7 centimeters in diameter in the lower abdomen, slightly to the right. The left lateral border was irregularly calcified. The opaque medium was visualized only in the right kidney on the 30 minute film. The right kidney was displaced laterally 6.5 centimeters from the lateral border of the vertebral body. On the third hospital day, a pulsating mass was palpated in the right lower quadrant. On the fifth hospital day, he died. At autopsy, an aneurysm was demonstrated which involved practically all of the aorta. It started at the level of the superior mesenteric artery and extended to 5 millimeters above the bifurcation.

CASE THREE

A 68-year old man was admitted to the hospital with severe right lower quadrant pain, vomiting and a temperature of 101. Urological consultation was requested with a provisional diagnosis of right renal colic. Cystoscopic examination and a right retrograde pyelogram were normal. The urine culture collected from the right kidney and bladder contained staphylococcus aureus. It was concluded that this man had a right pyelonephritis. The urinary tract was not considered to be the cause for his pain. On the fourth hospital day, he went into shock and died. A large saccular aneurysm, originating just below the renal arteries and extending to a point one centimeter above the bifurcation of the iliacs, was demonstrated. The aneurysm measured 14 centimeters long and 11 centimeters in its greatest diameter.

A series of 18 cases of abdominal aortic aneurysm hospitalized in the Atlantic City Hospital between 1951 and 1954 has been reviewed to correlate the important clinical features of this problem. They were evaluated from the standpoint of a physical mass, x-ray findings and the clinical diagnoses. As reflected in the table below, ten of the patients had a palpable mass and 8 had no palpable mass. Of this group of 8, four came to autopsy. Three of the patients were operated on. Two had dissecting aneurysms and in the third instance the type of aneurysm was not specified. The remaining case had positive x-ray findings.

10 cases—pulsating mass
8 cases—no palpable mass
4 cases—came to autopsy

1—saccular 14 by 11 cms.
1—saccular, "large"
1—saccular 7 by 4 cms.
1—dissecting

3 cases—operated on

2—dissecting
1—not specified

1 x-ray positive

The table below reviews x-ray findings in 18 cases. Eleven of the patients were x-rayed. Of this group, 7 had "positive" x-ray findings, 3 had presumptive evidence and in the final case, the x-ray report was negative.

11 cases x-rayed
7—x-ray positive
3—presumptive evidence
1—negative

In 7 instances, the only diagnosis was abdominal aneurysm. In 5, the diagnosis was not made, while in the remaining six patients abdominal aneurysm was included in the differential diagnosis. See below.

7—Aneurysm only diagnosis
6—Aneurysm included in differential diagnosis
5—Diagnosis was not made

Below are listed the diagnoses that were considered other than aneurysm and the number of time that each diagnosis was made.

Cholecystitis	3
Intestinal obstruction	3
Pancreatitis	3
Perforated peptic ulcer	2
Appendicitis	2
Neoplasm	2
Renal colic	4
Perinephritic abscess	1

The roentgenographic examination is the most important laboratory adjunct in evaluating this problem. Estes[10] in a series of 102 cases reports that 85 per cent of cases with abdominal x-ray, evidence was found pathognomic of aneurysm or consistent with it. The significant findings are:[11]

1. Visualization of calcification of the aortic wall.
2. Displacement of an abdominal organ.
3. Demonstration of a soft tissue mass with or without calcification of the periphery.
4. Absence of the psoas outline.
5. Erosion of the vertebrae without destruction of the cartilage.
6. Demonstration of the aneurysm by aortogram.

The aortogram may not demonstrate the aneurysm, inasmuch as the aneurysmal sack may be filled with an elastic clot.[14]

Abdominal aortic aneurysm is usually due to arteriosclerosis[2] while thoracic aneurysm is usually the result of syphilis.[14]

Therapy consists of excision of the aneurysm, suturing the defect or replacement of the aneurysm with a homograft or synthetic graft.[12,13] A graft[15] may be made if the aneurysm does not involve the renal arteries. The aneurysm may, however, involve the iliacs.[16]

CONCLUSION

THE diagnosis of abdominal aneurysm is sometimes a difficult one. It can simulate an acute abdominal surgical emergency. The urinary tract is frequently indicted as the source of the symptoms. A flat plate of the abdomen or an x-ray study of the abdominal viscera is the most important laboratory adjunct in arriving at a correct diagnosis.

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12. DeBakey, M. E., Colley, B. A., and Creech, O.: Journal of the American Medical Association, 155:203 (Jan. 15) 1955.
13. Sanger, P. W., Taylor, F. H., McCall, R. E., Duchesne, R., and Lepage, G.: Journal of the American Medical Association, 160:1403 (April 21) 1956.
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15. Humphries, A. W., deWolf, V. G., and LeFevre, F. A.: Journal of the American Medical Association, 161:953 (July 7) 1956.
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5610 Ventnor Avenue

Vaccine Therapy: 2-Edged Sword?

Spain and Fontana[1] discuss the effectiveness of autogenous respiratory vaccines prepared from infective respiratory tissues. They report that the autogenous antigens they used "must be employed with extreme caution and in high dilutions since it is usually quite possible to throw the patient into a severe, prolonged, and prostrating asthmatic condition or status asthmaticus with the injection of as minute an amount as a 20th of a milliliter of a 1:100,000 dilution of a 1 per cent heat-killed autogenous bacterial suspension."

Many years ago Cooke[2] stated, "Vaccine therapy is a two-edged sword to be used with caution in any allergy and especially in asthma . . . " and that he "has seen patients kept in status asthmaticus merely by vaccine injections."

As far back as 1929 Hektoen and Irons[3] in a survey of 1,861 physicians found that only 17 (less than 1 per cent) of the physicians considered vaccine therapy to be generally useful. Other physicians reported cases of asthma to have followed courses of bacterial vaccines administered to patients who previously were not known to have suffered from asthma.

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2. Cooke, R. A.: *Allergy*. Saunders, Philadelphia 1947. Page 151.

3. Hektoen, L. and Irons, E.: Journal of the American Medical Association 35:864 (February 1929)

Samuel Fisher, M.D.
Paterson

Treatment of Certain Dermatoses with A Colloidal Wet Dressing*

Wet dressings would be safe and effective remedies for many acute and subacute dermatoses, if they did not cause maceration and drying. By using an aluminum acetate-colloidal oatmeal dressing, Dr. Fisher was able to relieve most cases of dysidrosis, dermatitis venenata, pyoderma and seborrheic dermatitis.

With increasing frequency we see patients with severely inflamed skin conditions caused by the improper use of topical agents. Often, this has occurred shortly after the use of some sensitizing or harsh medicament. Usually these irritants are recommended by a kindly neighbor or relative. Sometimes the offending product was prescribed by a physician.

There are certain basic concepts in skin therapy which, if properly grasped, resolve most dermatoses without the need for the more expensive, and frequently, unnecessary "wonder" drugs. In fact, skillfully used, the time-tested agents often produce outstanding dramatic results.

Soothing wet dressings over the years, have proved satisfactory in relieving and healing most acute and subacute skin conditions. At once, these aqueous solutions are antipruritic, cleansing, antiphlogistic, analgesic, and safe. Which of the so-called "wonder" drugs have all of these attributes?

Over a period of years, I have tried a wide assortment of wet dressing. One of their few drawbacks is the tendency towards excessive maceration and drying, particularly when used too frequently or for long periods of time. Milk and other colloidal or water-modifying products have been added to the various dressings to reduce this undesirable tendency.

Within the past two years, a product has come to my attention, which, on the basis of clinical experience, avoids these drawbacks. This is a mixture of aluminum sulfate, calcium acetate and a colloidal oatmeal* in individually-dosed packets. The contents of this packet in water combines to form Burow's solution (aluminum acetate) in a colloidal oatmeal suspension. The oatmeal colloid affords protection against the excessive maceration and drying. Apparently this works by modifying or "taking the edge off" the frequently irritating tap water. In this preparation,* the Burow's solution is no longer carried in plain water. Instead, it is in the medium of a demulcent colloidal oatmeal suspension.

Patients, in practically all cases, tolerated these special wet dressings* better than ordinary Burow's solution. It was interesting to note that patients could utilize the special wet dressings* for longer periods of time and with greater frequency, thus speeding recovery. The

*The basis of this is Aveeno® colloidal oatmeal. Aveeno is a Fougera product. The Aveeno Company at 250 West 57 Street, New York, has combined Aveeno with Burow's Solution, and they call the combination Bur-Veen®, meaning, of course, Burow's Solution plus Aveeno. Throughout this paper, the "preparation" referred to is this tradenamed Bur-Veen® (Aveeno Corporation, New York).

dilution of the solution may be modified as desired, merely by adjusting the amount of water. Thus, one packet of Bur-Veen® wet dressing powder, added to one pint of tap water, makes the equivalent of a 1 to 20 Burow's solution, one Bur-Veen® packet to one quart provides the equivalent of a 1 to 40 solution. For most of our patients we used the 1 to 40 solution. It provided satisfactory results.

During the past two years, we treated 309 patients with Bur-Veen® soaks and wet dressings.* Of these, sensitivity to the wet dressings was found in only three patients.

In this study, the following conditions constituted the bulk of the cases. Good to excellent results were elicited in 97 per cent of the patients:

Contact dermatitis	77
Dysidrosis with secondary infection	28
Pyoderma	23
Seborrheic dermatitis	20
Nummular eczema	15
Dermatophytosis	14
Folliculitis	13
Intertrigo	12
Varicose ulcers	11
Atopic dermatitis	10
Dermatitis venenata	10
Tinea cruris with secondary infection	10

CASES OF DYSIDROSIS

1. A 30-year old man was first seen October 4, with vesico-pustular eruptions on the fingers of both hands. He had previously been treated for five months with no apparent results.

The patient was advised to use these special wet dressings* for one hour periods, three times daily, followed by a mild emulsion containing phenol 0.5 per cent, three times daily. He was also given superficial x-ray therapy ½ skin unit to the anterior and posterior surfaces of the hands. By December 1 of the same year, he was well and was using a tar ointment for the residual eczema.

2. A 14-year old girl was first seen June 29. She had an erythematous, vesicular eruption with secondary pyoderma on the palmar surfaces and sides of the fingers of two months' duration. This had previously been treated with lotions and ointments. The diagnosis obviously was dysidrosis with secondary infection.

She was placed on Bur-Veen® soaks* on June 29 for one hour periods, three times daily, followed by a hydrocortisone-oxytetracline ointment.[1] One week later, fingers of both hands were healing well and by July 8, both hands were clear of infection and were on the way to healing.

SEBORRHEIC DERMATITIS

3. A 47-year old woman was first seen January 12 complaining of itching with weeping behind both ears, with extension into the scalp. This had been present for six months. She had used several ointments without effect. I found erythematous, weeping, crusted areas behind both ears and extending into the scalp. There was some erythema and scaling of the naso-labial folds. There was some scaling in the scalp. It was my impression that this was seborrheic dermatitis with secondary infection.

Bur-Veen® soaks* for one hour periods three times daily followed by a neomycin-hydrocortisone compound[2] was ordered. When seen again on January 14 there was marked improvement and on January 21 she was discharged as recovered. She was advised to use anti-seborrheic measures in the scalp.

4. A 20-year old girl was first seen September 8. For 22 months following the use of a detergent, she developed a severe dermatitis involving both hands and fingers. Prior to seeing the patient she had used many different ointments, some of which caused more inflammation. She presented an erythematous, vesicular, cracked and pustular eruption involving the dorsum of both hands and fingers. My impression was a contact dermatitis caused by household detergents and by the local medications.

Patch tests proved positive to Clocream® (Upjohn), Acid Mantle Cream® (Dome) and hydrocortisone.

On September 8, Bur-Veen® wet dressings* were prescribed to be applied for 2 hour periods three times daily followed by 2 per cent Dernaftan® (Vacro) in zinc oxide ointment. Grenz ray therapy, 100 roentgens, to the dorsum of both hands was given for 16 treatments. Five days later, the Dernaftan® was discontinued because of sensitivity and a new ointment consisting of phenol 0.3, aluminum acetate solution 10.0, anhydrous lanolin 20.0, unguentum zinc oxide and unguentum aquaphor ad 60.0, was substituted.

Seen at five day intervals, she continued to improve. During the course of therapy there were remissions and exacerbations following exposure to soaps and other household articles. With each recurrence Bur-Veen® wet dressings,* followed by the above ointment, were used with good results. She was kept under observation for one year and when last seen both hands were clear.

5. A 52-year old man was first seen May 3. After working as a dyer's helper for three years, both hands and forearms suddenly "broke out," one week prior to the first visit.

There was an erythematous, vesicular eruption involving the dorsum of the hands and the anterior surfaces of the forearms. For the acute vesicular process, Bur-Veen® wet dressings* were applied for two hour periods, three times daily for

1. I used the Pfizer brand tradenamed Terra-Cortril Ointment®.

2. In the form of the Upjohn tradenamed product Neo-Cortef®.

three days, and thereafter, for one hour three times daily for one week. Following the wet dressing, a mild emulsion with phenol 0.5 per cent was applied. The patient was seen again after five days and was given ⅛ skin unit x-ray therapy to the dorsum of the hands and forearms. Therapy was repeated every five days. Patch tests were positive to a dye used at work. The patient was discharged as recovered on June 14.

DERMATITIS VENENATA

6. A 59-year old woman was first seen October 26. She said she thought she was stung by a mosquito one week earlier. She had an erythematous, vesico-bullous eruption with weeping on both legs and thighs. The diagnosis was dermatitis venenata. Bur-Veen® wet dressing* for one hour three times daily followed by an emulsion containing 0.5 per cent phenol resulted in swift recovery. She was entirely well on November 8th.

7. A 26-year old woman was first seen June 7. She said she had been gardening four days earlier. Following this, she noticed large blisters on the arms and legs. She had many bullae and vesicles with weeping on both legs and forearms. Some of the vesicles were in linear arrangement. The diagnosis was obviously dermatitis venenata.

A wet dressing* of Bur-Veen® was ordered for two hour periods three times daily for two days and, thereafter one hour three times daily for two days, followed by a mild emulsion with 1.0 per cent phenol. She responded well to therapy and was discharged as recovered July 2, 1955.

SUMMARY

Wet dressings are a time-tested method of providing relief in many acute and sub-acute dermatoses. However, they may cause excessive maceration and drying.

A series of 309 patients utilizing a new type of wet dressing is presented. Bur-Veen® wet dressings and soaks* provide the acknowledged benefits of other soothing wet dressings and, in addition, are conspicuously less likely to lead to drying and excessive maceration. Because of this, these colloidal soaks and dressings were used for periods up to two hours, several times daily, as compared with the 20 or 30 minute periods generally used with the old forms of wet dressings. These prolonged treatment periods with these wet dressings* helped speed relief and recovery in the great majority of patients. This procedure reduced the possibility of irritation, a common complication with ordinary wet dressings.

808 Madison Avenue

Wind Instruments and Lung Power

Playing of wind instruments is an excellent form of breathing exercise, and (in moderation) is beneficial rather than otherwise to sufferers from respiratory disorders, according to the British Medical Journal.*

There is little satisfactory evidence of any kind about the etiology of emphysema, and none at all about the part played by wind instruments.

"One must fall back, therefore, on rather vague generalizations, based on the known properties of various instruments and the physiology of respiration."

Instruments of the oboe family are the most exhausting to play. The performer is required almost to hold his breath for long periods, while sustaining a considerable air pressure. The flute requires the expenditure of considerable volumes of air, so that the player has to take rapid deep breaths at the end of prolonged expiration. The clarinet and saxophone occupy an intermediate position and could therefore be said to be the most suitable for a player with limited respiratory powers."

*Wind Instruments and Emphysema, British Medical Journal 1:1058 (May 5) 1956

Benjamin K. Silverman, M.D.
Princeton
Marian R. Stanford, M.D.
Trenton
A. Joseph Hughes, M.D.
Camden

Cardiac Case-Finding Through Community Chest Surveys

Everyone knows about the chest x-ray program. But many do not know that it pays an extra dividend: it unearths some otherwise unsuspected cases of heart disease. Out of 115 thousand such x-rays, 3700 had findings suggestive of heart disease. Dr. Silverman is the Coordinator of the Heart Disease phase of the program; Dr. Stanford is Director of the Division of Chronic Illness Control; and Dr. Hughes is a Public Health Physician in the Tuberculosis Control Program.

Nearly everybody knows about the chest-screening survey for tuberculosis administered by the Division of Chronic Illness Control of the New Jersey State Department of Health. Not many, however, are aware, of the important corollary project for cardiac case-finding which is an offspring of the tuberculosis program. The purpose of this paper is:

a. To familiarize the physicians of the state with the existence of the cardiac case-finding project.
b. To encourage the return of a larger proportion of the cardiac follow-up forms mailed to physicians as a result of an apparent cardiac abnormality appearing on a patient's 70 millimeter chest film; and
c. To report the number of cardiac cases diagnosed by physicians and brought to medical care as a direct result of the program during 1955.

Basically, the chest-screening program follows this pattern:

1. An individual voluntarily appears at a state chest-film unit for the purpose of having a chest x-ray. At the time, he names his own private physician or clinic.

2. The 70 millimeter antero-posterior film is read by a trained radiologist. His reading is acted upon in one of three ways:

(a) If the reading is negative, the individual is so informed by mail.

(b) If the reading reveals suspected pulmonary pathology, notification is sent to his designated physician, to the local public health officer, and to the subject himself for follow-up.

(c) If the reading reveals suspected cardiac abnormality, the subject is notified that his recent x-ray suggests a condition requiring further medical examination; and that he should report to his physician. The physician is simultaneously notified of the reading ("cardiac enlargement" or "aortic enlargement" over 95 per cent of the time). A form is provided for the physician to notify the Heart Disease Control Program of his findings on

examining the patient. The local health officer is not notified of suspected cardiac abnormalities, and the Heart Disease Control Program does no further follow-up on these individuals. In most areas of the state, the physician can request nursing and social service follow-up care for his patient, if he feels it indicated.

Table 1 reveals the over-all figures for the Community Chest X-ray Survey for 1955. Of the 115,434 films read, 93 per cent showed no suspicion of abnormality. Abnormality was suspected on 7921 films. Of these 845 showed two suspected conditions, making a total of 8766 abnormalities. Actually, there were slightly more films read as showing suspected cardiac abnormality than suspected tuberculosis.

TABLE 1. COMMUNITY CHEST X-RAY PROGRAM, 1955. DIVISION OF CHRONIC ILLNESS CONTROL, NEW JERSEY STATE DEPARTMENT OF HEALTH

Total number of persons x-rayed	115,434
Number of persons found with abnormalities	7,921
Number of abnormalities found	8,766

Abnormalities	Number	Per Cent
Suspected cardiac	3,736	43
Suspected cancer	242	3
Suspected tuberculosis	3,707	42
Other	1,081	12
	8,766	100

Of the 3736 suspected cardiacs, 764 also showed possible tuberculosis and were therefore followed up by the Tuberculosis Control Program. The remaining 2972 were referred to the Heart Disease Control Program for follow-up in the way outlined above. The data regarding these is presented in Table 2.

The following salient points may be gathered from the data on the 1093 individuals about whom forms were returned by their physicians:

(a) Of the 1093, all but 70 (6½ per cent) were known to have or found to have cardiovascular disease in some form.

(b) Of the 1093, 125 (11 per cent) were discovered to have some form of cardiovascular disease for the first time and were brought to medical care as a direct result of this program.

While we are aware of the benefits which may accrue to the 125 (or 11 per cent) who were brought to medical care earlier as a result of this program, we are equally aware of the potential harm which could be done to the 70 (or 6½ per cent) in the form of "psychogenic heart disease." For this reason, we do not notify local health officers of suspected cardiac abnormalities and do not follow-up these individuals beyond the simple suggestion that they visit their doctor for an examination.

TABLE 2. FOLLOW-UP OF SUSPECTED CARDIAC ABNORMALITY
HEART DISEASE CONTROL PROGRAM
DIVISION OF CHRONIC ILLNESS CONTROL
NEW JERSEY STATE DEPT. OF HEALTH

2a.	Number of cardiac suspects	3,736	
	Number with tuberculosis also suspected and followed up by TB Program	764	
	Referred to Heart Program for follow-up	2,972	
	Number over 70 years of age	507	
	Number referred to physicians by Heart Program		2,465
	Number of replies received from physicians		1,093
2b.	Breakdown of 1093 replies:		
	Number of patients who reported for re-examination		898
	Number who did *not* report but were known to physician as heart cases		191
	Number who did not report and physician had no knowledge of case		4
			1,093
2c.	Breakdown of 898 cases who reported for further examination:		
	Cardiovascular disease present		832
	Cardiovascular disease not present		65
	Cardiovascular disease unknown		1
			898
2d.	Breakdown of 832 cases who reported for further examination and had cardiovascular disease:		
	Diagnosis known prior to this survey		707
	Diagnosis not known prior to this survey		125
			832

Table 3 gives more detailed diagnostic data on the 125 discovered to have cardiovascular disease for the first time. Arteriosclerotic and

hypertensive cardiovascular diseases make up the majority of this group.

TABLE 3. TYPE OF CARDIOVASCULAR DISEASE IN 125 "NEWLY DISCOVERED" PATIENTS

Hypertensive		43
Arteriosclerotic (including coronary artery)		41
Rheumatic		14
Mitral stenosis	4	
Mitral insufficiency	2	
Not specified	8	
Congenital		1
Ventricular septal defect	1	
Luetic		1
Cor pulmonale		1
No diagnosis given		24

Some of the comments made by physicians returning forms regarding these 125 patients are worth noting:

1. A physician in Bridgeton, discovered his patient to have severe hypertensive cardiovascular disease (270/160 blood pressure) and says: "Patient was entirely asymptomatic and would not have reported for care had x-ray not been taken and followed-up."
2. A physician in Irvington, whose patient was previously completely well, notes that "patient called me in when in acute coronary attack; now in hospital in oxygen."
3. Physicians in Fanwood and Carteret in reporting newly discovered cases of arteriosclerotic heart disease, commented that their patients had not been to a doctor in 8 and 4 years.

The value of the 70 millimeter antero-posterior film in cardiac case-finding varies greatly with the skill and interest of the "reader" in cardiovascular disease. It has also been shown that the addition of a lateral chest film does not assist the "reader" in sorting out heart disease. No studies have been reported utilizing oblique views in conjunction with antero-posterior film on a mass basis.

SUMMARY AND CONCLUSIONS

1. The Community Chest x-ray Program as administered by the Division of Chronic Illness Control of the New Jersey Department of Health has an important, though little known, corollary objective; cardiac case-finding. The cardiac follow-up method is described.
2. Analysis of the 1955 cardiac follow-up forms reveals that, of 1093 individuals on whom data are complete, 1023 were known to have or found to have heart disease of some type. 125 of these were brought to medical care for the first time.
3. It is the opinion of the Heart Disease Control Program of the Department of Health that the 70 millimeter antero-posterior chest x-ray is a helpful adjunct in cardiac case-finding on a mass basis and constitutes another important reason for individuals to avail themselves of the opportunity to have an annual chest film.

The State House

Unintended Coronary Sinus Catheterization

The Read-Bond-Porter syndrome is a signal of the unintended and unrecognized entry of a cardiac catheter into the coronary vein. The syndrome* resembles myocardial infarction. At first it looks as if the catheter tip had entered the outflow tract of the right ventricle and as if it would pass no further. The authors propose a method* based on their experience with deliberate catheterization of the coronary sinus, to avoid this potentially fatal syndrome. This is based on the appearance of the catheter in the anteroposterior instead of the right oblique position; the visible difference in oxygen content of blood coming from the coronary vein as contrasted with that from the right atrium or ventricle; the difference in blood pressure readings at the two sites.

*Read, J., Bond, E. and Porter, R.: Archives of Internal Medicine, 96:176 (August 1955)

Your Responsibility Under the 1956 SSL

The role of the physician in the determination of an applicant's claim for total disability or a "disability freeze" under the 1954 Old Age and Survivors Insurance Amendments of the Social Security Law was discussed on page 40 of the January 1956 issue of this JOURNAL. Purpose of the 1954 amendment was to grant this "disability freeze" to people who had become totally and permanently disabled for more than six months prior to age 65 so as to prevent a loss or a material reduction in future old age and survivors insurance benefits. The medical report form completed by the physician had to contain sufficient clinical information so that a review team from the State Office of the Old Age and Survivors Insurance (OASI) could definitely determine whether the applicant was entitled to the "disability freeze" provision because of inability to be substantially and gainfully employed.

On August 1, 1956, the Social Security Act was further liberalized. Starting July 1, 1957, the new Social Security Law will provide monthly disability payments at age 50 (cash benefits) to permanently disabled workers who meet certain eligibility requirements and who submit definite medical evidence that they are totally disabled and incapable of engaging in substantial remunerative employment.

At present, adult children who had become totally disabled before age 18 are also entitled to monthly benefit payments under the new act. The "disability freeze" still applies to persons not eligible for cash disability insurance benefits because they have not attained age 50.

The effective date for the cash benefit program was October 1, 1956. An applicant will have to furnish medical proof that he has a "medically determinable physical or mental impairment which can be expected to result in death or be of long-continued and indefinite duration." This condition must have existed for at least six months and the applicant must be willing to undergo the vocational rehabilitation offered by the state rehabilitation agency.

The scope and responsibility for determining total disability in a person 50 years of age or younger is greater and more difficult than in a person 60 years or more. For example, it may be easier to grant a "disability freeze" to a hemiplegic age 62 than to a hemiplegic age 50 who has greater recuperative power and who may have rehabilitation potential. It will also be difficult to make this determination in women applying for these benefits who have borderline conditions and who do not have strong motives for continuing employment. There will be many instances where family physicians will be pressed by applicants to "stretch" their clinical judgments in favor of declaring them totally and permanently disabled. In many instances the alleged disabilities will fall short of the intention of the new amendments. Therefore, a disability claim will require mature clinical judgment and exact clinical evidence from treating physicians. The cooperation of all physicians in the submission of careful, thorough, clinical statements and opinions will enable the review teams to render final recommendations and decisions. Similarly, physicians on review teams will, of necessity, have to be rigid and exact in interpreting findings and in reaching their conclusions. Much time and labor will be saved if the physician can definitely determine the date the applicant became totally disabled. Furthermore, the form must indicate the *medical* reasons why the applicant cannot engage in substantial work and reflect the severity of the disability as well as the expected duration. At times, an additional letter concerning the development and status of the disability, supplementing information on the medical form, will be of material help. This will be particularly important in the development of disability for children disabled before the age of 18.

The responsibility for obtaining the medical proof, including the completion of medical forms by physicians, hospitals, and laboratories, still rests with the applicant.

This new law may require additional paper work for treating physicians. In many instances family physicians will be put on the spot in meeting the demands of their patients and in many instances the patience of the physician may be strained. Physicians on the whole, however, will recognize their responsibility to their patients and their government.

HENRY A. BRODKIN, M.D.
Medical Director
N. J. Department of Labor and Industry

Hospital Disaster Planning

In and after 1957, the AMA will not approve for internship any hospital that fails to prepare a "disaster" plan. This advice has, of course, caused hospitals to start thinking about such plans; or, in some cases, to re-evaluate plans previously developed. In this connection, Dr. R. Winfield Betts, chairman of our Special Committee on Emergency Medical Service and Civilian Defense submits the following report:

The New Jersey Hospital Association's Committee on Disaster Planning, in an effort to gear its activities to the needs of the hospitals, recently sent out questionnaires to the hospitals to determine the current state-wide status of hospital disaster planning.

Of the 130 questionnaires sent out, there were 71 replies. Following is a brief summary of the tabulations and also an indication of the job that must be faced by the hospitals:

(a) Thirty-eight hospitals have written plans for handling local disasters with some 10 of these hospitals now revising the plan.

(b) Twenty-two hospitals stating that they now have no written plan, are in the process of drafting one.

(c) Eighteen hospitals report that they have had "dry runs" of their plan and 14 others expect to have one.

(d) Twenty-four hospitals have volunteer groups such as Red Cross included in their plan but only 20 hospitals have their plan coordinated with the local Civilian Defense office. (16 hospitals have received equipment from the local C.D. organization.)

(e) Thirty-five hospitals indicated that their medical staffs were organized as part of the disaster plan with only one hospital reporting that its medical staff was not in sympathy with such a plan.

As the situation stands today (based on the tabulated returns), less than half of the institutional members of the Association either have or are drafting written disaster plans. The first objective is to have all hospitals draft a plan best suited to the individual needs. Whatever plan is decided upon will be of little value unless it is closely integrated with the medical staff, volunteer and local civilian defense groups.

When their study is completed, the Committee will make a formal report to the member hospitals. In the meantime, the Association strongly urges hospitals that have not already done so, to give immediate consideration to the development of their own plans. Otherwise they face the danger of having their accreditation withdrawn.

Blood *Is* Thicker Than Water!

Are you asking yourself, "Is *this* blood really necessary?" Are you aware that hypervolemia is not an uncommon cause of death? If your patient has "tired blood," you may be slugging him with an additional burden from which he may not recover. It is not possible to screen all carriers of hepatitis virus. It is also well known that some people are just as happy with 6 or 7 grams of hemoglobin as others with 14 or 15. Pouring blood into a weakened myocardium can and often does produce congestive failure. There are many more reasons for treating blood with respect. The important thing is: What to do about it?

1. Get your requisitions into the laboratory early. The blood bank technologist is handpicked for the job. She can detect incipient problems promptly. Don't rely upon the night emergency people who are busy with "stat" sugars, blood counts, amylase, and so on, to exercise the same degree of skill and caution as highly qualified specialists in blood banking.

2. Reserve blood administration to people under anesthesia only in dire emergencies. Reactions cannot be recognized promptly.

3. Do not routinely use antihistaminics. These can mask minor reactions. Subsequent transfusions may be fatal.

4. Insist that responsible people *personally* verify the data on the label of the blood bottle and check against the recipient's hospital or admission number.

5. Group "O" blood is not really the universal donor blood. Use only in dire emergencies.

6. When in doubt, consult with your pathologist.

7. If blood transfusion is necessary, alert the patient's family to replace promptly. There is no substitute.

By New Jersey Society of Clinical Pathologists. (Adapted from material released by the Texas Society of Pathologists)

Obituaries • • •

DR. LEO V. BECKER

One of Passaic County's most useful citizens died on October 19, 1956. He was Leo V. Becker, M.D., who was at one time President of the State Board of Medical Examiners. Born in Paterson in 1878, he was graduated in 1906 from the medical school of the University of Maryland. He was an accomplished linguist and was probably the only member of The Medical Society of New Jersey to function as a full professor of Latin. Dr. Becker taught both French and Latin at St. Benedict's Academy in Newark during the closing years of the 19th century. He was, at one time a Police Commissioner, and also served a term on the Paterson Fire Board. For six years (1932 to 1938) he was a Passaic County Freeholder. An F.A.C.S., he was active in the Passaic County Medical Society, in the Elks and in the Knights of Columbus.

DR. ALVIN S. MASON

On October 25, 1956, Dr. Alvin Mason—who for 35 years had well served the people of Salem County—died in a New York hospital at the age of 73. A graduate of Howard University medical school (class of 1911) he practiced briefly in his native Virginia and then moved to Salem, N. J. He was chief of venereology at the Salem Hospital and was, for years, reporter for the Salem County Medical Society. He was active in many civic affairs in southern New Jersey and in Philadelphia.

DR. CLARENCE W. WAY

One of the most colorful figures in New Jersey medicine was surely the late Clarence W. Way. He was born in 1882, and died at the age of 74. In Cape May County he was born, and in Cape May County he died, and in between he travelled the world. The University of Pennsylvania gave him his M.D. degree in 1909, and after an internship in Williamsport, Pa., he returned to his native county. After 5 years of practice, and just at the point where it was getting to be a big practice too, he volunteered his services to the U.S. Army. He went to AEF Hospital No. 1 in Paris. At the end of the war, the Government asked him to remain in Federal Service to administer medical activities on behalf of the Red Cross and other agencies striving to bring relief to a war-torn world. In that capacity, Dr. Way moved from France to China and back, helping organize medical missions and furnishing medical assistance to civilian relief agencies.

He returned to Cape May County and picked up the threads of his practice. Before leaving Paris, he became a charter organizer of the American Legion—Post 1. He held all the offices in the Cape May County Medical Society. He established the *Bulletin* of the Society, and made it one of the liveliest little medical bulletins in the country. He organized Sea Isle City's Rotary Club. In 1939 he created a unique publication, *The Medical Way*.

In 1942, at the age of 60 he again left a prosperous practice to serve the medical corps of the Army. He clamored for foreign service, but the Surgeon General kept him in senior posts at general hospitals in the states. When World War II ended he returned to South Jersey to continue his service to his friends, neighbors and patients. And there, on July 30, 1956, he died in harness as he would have wished.

Course in Traumatic Surgery

Beginning April 10, 1957 in Chicago an intensive practical course on fractures and other trauma will be offered to American physicians. The course will include clinical presentations, lectures, and demonstrations. Subjects to be covered include: injuries to bone and soft tissue; bone grafting; traction; injuries on the farm; burns; vascular trauma; amputations; industrial casualties and head injuries.

For further information write to Dr. John J. Fahey, 1791 W. Howard St., Chicago, Ill. This course is sponsored by the American College of Surgeons.

Announcements • • •

Gastro-Enterology Symposium

On Saturday, January 12, 1957, the New Jersey Academy of General Practice will hold a gastro-enterology seminar in Asbury Park at the Berkeley-Carteret. The program follows:

10 a.m.—"Common Disorders of the Esophagus" by Max L. Som, M.D., Associate Professor of Neck Surgery, Bellevue Medical Center, New York.

11 a.m.—"Pitfalls in the Management of Stomach and Duodenal Ulcers," by Harry Shay, M.D., Professor of Medicine, Temple University, Philadelphia.

12:30—Luncheon — Courtesy of Ortho Laboratories.

2 p.m.—"Functional Versus Organic Patterns of the Colon," by Berthold Weingarten, M.D., Physician-in-Chief, Gastro-enterology Service, Montefiore Hospital, New York City.

3 p.m.—"Inflammatory Lesions of the Small Intestine," by J. Arnold Bargen, M.D., Chief, Department of Intestinal Diseases, Mayo Clinic, Rochester, Minnesota.

4 p.m.—"Practical Aspects of Office Proctology, Richard A. Hopping, M.D., Attending Proctologist, St. Barnabas Hospital, Newark.

6 p.m.—Buffet, Social Hour and Dance, Courtesy of Pfizer Laboratories.

All physicians are invited. Registration fee of $5 for non-members. Entertainment will be provided for the ladies.

Glaucoma Lecture

On Saturday morning, February 9, Dr. John M. McLean will lecture on "Management of Glaucoma." This is the annual Bedell Lecture sponsored by the Wills Eye Hospital at 1605 Spring Garden Street in Philadelphia. The lecture is scheduled for 11 a.m. All physicians interested in glaucoma are welcome.

Courses at Mt. Sinai

Announcement is made of the following courses at Mt. Sinai Hospital, 1 East 100 Street, New York City. This program is in conjunction with Columbia University. For more information write to Postgraduate Registrar, Mt. Sinai Hospital, 1 East 100 Street, New York 29, N. Y.

All dates are 1957:

PART-TIME COURSES

Physiology of the Digestive Tract—January 9 to May 8

Surgical Pathology—January 19 to April 27

Heart Disease and Circulatory Dynamics — February 19 to April 23

Hematology, Laboratory Methods in—February 25 to March 21

Roentgen Diagnosis of G. I. Lesions—March 4 to 15

Radiology of the Chest—March 18 to 26

Laboratory Methods in Blood Banks—April 2 to May 7

FULL-TIME COURSES

Voice Rehabilitation—February 11 to 16

Minor Surgery—January 7 to 9

Elementary Electrocardiography—January 14 to 18

Advanced Electrocardiography—January 21 to 25

Cardiovascular Diseases—January 28 to February 8

Office Proctology — February 18 and 19

Neurology—April 1 to 5

Gastroenterology—April 8 to 12

Audiology—February 11 to 16

COURSES FOR SPECIALISTS

Indirect Laryngoscopy—February 11 to 16

Mobilization of Stapes—March 18 to April 5

Trans-meatal Surgery—April 8 to 19

Radium Therapy—April 30 to June 11

Radioactive Isotopes—June 3 to 28

Rhinoplasty and Otoplasty—July 13 to 27

County Society Reports . . .

Atlantic

"Gout" was the topic for the scientific session of the *Atlantic County Medical Society* on October 12. The speaker was John H. Talbott, M.D., professor of medicine at the University of Buffalo. Dr. Whims and Dr. Wilner opened the discussion.

The business meeting was then opened by the president, Dr. Baxter Timberlake. Recommended for associate membership were Drs. Herbert Cohn, Joseph Mann and Alfred Rosenblatt. Their election was approved.

The following resolution was read:

> Whereas, the By-Laws of the Medical Society of Atlantic County, New Jersey, states in Article IV, Section 3, that emeritus members are of the following group:
>
> "This group shall include physicians who have been members in good standing for at least twenty years, and who by reason of age or infirmity have retired from the active practice of medicine, or such members of the Society who have been totally disabled by reasons of military service."
>
> Whereas, John Pennington, M.D., has been in the practice of the specialty of ear, nose and throat, in the Atlantic City area for over thirty-five years, and,
>
> Whereas, John Pennington has now retired from active practice,
>
> It Be Resolved that John Pennington be elevated to the honored status of emeritus member of the Medical Society of Atlantic County.

The resolution was unanimously adopted and a copy is to be sent to John Pennington.

Dr. Timberlake announced that Mr. George Buzby of the Hotel Dennis has offered to entertain the speakers and their wives, on the American plan, for the weekend, when they are in Atlantic City, appearing before our Society. The Society appreciates the fine offer of Mr. Buzby.

There was considerable discussion about the expenses incurred by speakers when they come to appear before our Society. It was agreed that the Society offer to pay traveling expenses of speakers who are not on the "Visiting Chief" program.

The application of Dr. Barrone, now on the staff of the State Hospital, Ancora, was referred to the Censorship Committee.

There being no further business, the meeting adjourned, and the members of the Society and the Woman's Auxiliary enjoyed the entertainment of George Tonak.

LEONARD B. ERBER, M.D.
Reporter

Camden

The regular monthly meeting of the *Camden County Medical Society* was held on November 6, at Our Lady of Lourdes Hospital, with Dr. George P. Meyer, President, presiding.

Mr. Philip Jones, Chairman of the Community Chest Drive, spoke to the Society concerning doctors' donations to the Chest and their participation in the Drive.

Dr. A. M. K. Maldeis read a memoir on the passing of Dr. Griscom, and the Secretary, Dr. F. J. Hughes, read a similar memoir submitted by Doctors George B. German, Herbert F. Johnson and himself on the death of Dr. Albert B. Davis.

Dr. Elmer L. Grimes, Program Committee Chairman, turned the meeting over to Dr. Robert L. Breckenridge. Cases were presented by Doctors George P. Meyer, Jordan, Mischinski, Grimes, Kelly, Mazur, Rosenberg, Onofrio and Block.

Doctors Charles E. Grimm, Howard D. Easling, William G. Field, William T. Goulburn, Clarence L. Lehman, Thomas W. Madden, John A. Marchesani, Martin H. Weinberg and Edwin E. Ziegler were elected to membership.

EUGENE H. KAIN, M.D.
Reporter

Cumberland

The October meeting of the *Cumberland County Medical Society* was held at the Seabrook Farms, Seabrook, N. J., on October 9, with Dr. Sherman Garrison, the President, presiding.

Dr. Albert Kump, President-elect of The Medical Society of New Jersey, was presented. He outlined the objectives of the State Medical Society, referring to legislation, public relations, indoctrination of new members in county societies and attendance at meetings of the county and state societies.

Dr. Carl Ware, of Shiloh, Dr. Mary Bacon and Dr. Sherman Garrison, of Bridgeton, were appointed to act in an advisory capacity and to collaborate with Dr. Kump during his term in office in the activities of the State Medical Society.

To expedite the voluminous activities of the secretary of the society, a committee was appointed to study her duties and to provide adequate facilities for handling them.

The remunerative problems of the pathologists, anesthesiologists, roentgenologists, relative to the hospital plans were discussed at length and many views were expressed.

Dr. Nicholas Marchione of Vineland, chairman of the Welfare Committee, reported that the trustees of the State Medical Society had approved the medical care program for the dependents of members of the armed forces.

Dr. Sidney Siegel of Millville, chairman of the Diabetes Detection Drive, read a letter from the New Jersey Diabetes Association explaining the nature of the drive this year. In addition to the work of the diabetes committee and lay groups, one physician in each community will be designated to screen all patients coming to his office for a period of one week.

Particular attention was drawn to the present adoption law which states: "Anyone (including physicians, obstetricians, pediatricians, and nurses) in any manner assisting in the placement of a child for the purpose of adoption is guilty of a misdemeanor."

An inspection tour of the Seabrook Farms processing plant was conducted by the hosts after the completion of the business meeting.

To conclude the activities, a steak dinner was served.

LEONARD G. SCOTT, M.D.
Reporter

Hudson

With Dr. John E. Annitto presiding, the first regular monthly meeting of the administrative year of 1956-1957 was held at Murdoch Hall, Jersey City, on October 2.

The following were elected to active membership: Dr. Samuel D. Critides of Jersey City; Dr. Peter Gruenwald of Bayside, N. Y. (practicing in Jersey City); Dr. Herbert A. Hartfiel of Westfield (practicing in Jersey City); and Dr. John P. O'Rourke of West New York.

Guest speaker was Dr. Saul Krugman, Associate Professor of Pediatrics, N.Y.U. College of Medicine, and Visiting Pediatrician at Bellevue Hospital on the subject of antimicrobial agents—evaluation and use in pediatrics. Dr. Israel Chanin, Dr. Samuel Prince, and Dr. Jacob L. Rosenstein were among the discussants.

HAROLD C. BENJAMIN, M.D.
Reporter

Middlesex

The monthly meeting of the *Middlesex County Medical Society* was held on October 17 at the Roosevelt Hospital, Metuchen, with the President, Dr. Sidney D. Becker, in the chair.

The Chairman of the Judicial Medical Ethics Committee, Dr. B. F. Slobodien made the following recommendations:

To regular membership, by transfer from the Steuben County Medical Society, Dr. William Jarrett, New Brunswick. To regular membership from associate membership, Dr. Vincent J. Cannamela, Metuchen. To two-year associate membership: Drs. Harry Fidler, New Brunswick; Leon Martin, Metuchen and Severin J. Ambrosia, Old Bridge. There being no objections, these were unanimously accepted. The Committee recommended that the following, who have announced their retirement from practice, be transferred to honorary membership: Drs. Pauline Long, Laurence Runyon, Robert Walker, all of New Brunswick and S. Messinger of Carteret. This was approved without dissension.

Dr. Slobodien announced that the members who are enrolled with the Blue Cross Group basis Plan might look forward, in the near future, to Medical-Surgical coverage.

Dr. Becker presented his views concerning persistently poor attendance at meetings. He said he is considering a door prize following each meeting, which would be donated by a medical supply house. Also announced were graduate courses in internal medicine in Perth Amboy and at the Middlesex General Hospital.

Dr. Sandella, for the Public Health Committee, noted that the State will continue to offer Salk vaccine to the various communities. There is now an adequate supply and it is recommended that adults be urged to participate in the vaccination program.

Our honored guest, Dr. Burrill B. Crohn, discussed with great clarity and understanding "Steroid Therapy in Ulcerative Colitis and Regional Ileitis." A brief question and answer period followed.

Dr. Moolten presented a detailed report of the statewide program for blood banks. A motion was made that the recommendation proposed by the Blood Bank Commission to the Trustees of The Medical Society of New Jersey be accepted. It was further moved that the headquarters for the Middlesex County Blood Bank be in New Brunswick. These were seconded and passed.

The Middlesex County Medical Society voted to inform the Trustees of The Medical Society of New Jersey, of its dissatisfaction with the proposed "Revision of the Code of Ethics" to be presented at the A.M.A. Meeting in November 1956. The replacing of our present Code of Ethics with an inferior statement of principles will leave the profession in a state of confusion. The Middlesex County Medical Society asks the Trustees to instruct our delegates to oppose the proposed revision of the A.M.A. *Code of Ethics.*

A motion was made by Dr. S. David Miller that each regular member of the Middlesex County Medical Society be given a credit of $5.00 (on the State Society assessment for 1957) to offset an amount donated by the State Medical Society to the American Medical Education Fund. This was seconded by Dr. Dunham and was happily passed.

MORTON M. KLEIN, M.D.
Reporter

Monmouth

The seventh annual summer dinner-dance of the *Monmouth County Medical Society* and its Woman's Auxiliary was held at Joseph's, West Long Branch, on September 8. Dr. and Mrs. Joseph F. Raffetto were co-chairmen of the affair which was enjoyed by the 179 who attended.

The regular monthly meeting of the Society was held at Monmouth Memorial Hospital, Long Branch on September 26 with Dr. John Hardy, the President, presiding.

As the first order of business, Dr. Hardy introduced Dr. Lewis C. Fritts, President of The Medical Society of New Jersey, and Mr. Richard I. Nevin, Executive Officer. Dr. Fritts conveyed official greetings to the members and expressed to them the appreciation of the State Society for the cooperation and spirit of the Monmouth County Medical Society. Mr. Nevin spoke briefly of some of the complicating social and economic attitudes which confront organized medicine in these times.

Drs. Howard Pieper and Harry Brindle were elected to fill the two vacancies on the Judicial Committee. Dr. Howard Pieper was also elected to fill a vacancy as a Delegate to the State Society, and Dr. Jacob Goldberg was elected an Alternate Delegate.

Elected to active membership were: Drs. Leonard S. Danzig and Harvey L. Marcellus, Fair Haven; Herbert N. Engel, Long Branch; Donald S. Littman, Little Silver; Gordon R. Smith, New Shrewsbury; and Ernest Stitch, Red Bank.

Associate membership was granted to Drs. Alexander D. Brickler, Long Branch and Irwin J. Polk, Red Bank.

During the scientific meeting, the Society heard Dr. Parker Vanamee of the Surgical Research Department of the Sloan Kettering Institute, speak on Electrolyte Alterations in Hepatic Coma."

Fitkin Hospital was host to the *Monmouth County Medical Society* at its regular meeting on October 24, with Dr. John W. Hardy, the president, presiding.

Dr. N. Allen Norman, Elberon, was elected to active membership, while Dr. Patrick F. Enright became an associate member.

A resolution was passed unanimously commending the First Aid Squads of Monmouth County for the fine work and splendid service they have rendered the citizens of this county.

The scientific session featured an interesting talk on *Cytology in Gynecologic Practice*. Dr. E. L. Hecht, Chief of Cytology Laboratory, Department of Gynecology, Bellevue Medical Center, was the speaker.

DONALD W. BOWNE, M.D.

Reporter

Morris

The *Morris County Medical Society* met on October 18 at Warner Chilcott Auditorium in Morris Plains. In the absence of the President, Dr. Robert F. Zimmerman, Vice President, chaired the meeting. Dr. Daniel Carroll introduced the speaker, Lieutenant Colonel Joseph E. Goldstein, United States Army. Dr. Goldstein is Assistant Chief of the Department of Atomic Casualty Study at Walter Reed Hospital. The speaker addressed the Medical Society on the handling of mass casualties.

At the business session, the society agreed to list separately in the telephone classified pages doctors willing to take emergency calls. A communication on fluoridation of water supply was referred to the health committee for study. The Society voted to make public a report of the Advisory Committee on Poliomyelitis control and to offer a press release advising the public to avail themselves of the Salk Vaccine now alloted for all age groups.

ALBERT ABRAHAM, M.D.

Reporter

Passaic

The regular meeting of the *Passaic County Medical Society* was held on Tuesday, October 16, at the Medical Society Building. Dr. Abraham Shulman, the President, presided.

The Treasurer, Dr. Frank B. Vanderbeek, reported briefly on the recommendations made by the Finance Committee in connection with membership dues for the year 1957.

Upon motion, it was voted that the County and State dues for 1957 be established as follows:

Passaic County Society Dues	$35.00
Per Capita Tax to The Medical Society of New Jersey	$35.00
Total	$70.00

It was voted that this Society contribute $10 to the American Medical Education Foundation, at the death of a member of this Society, in memory of the deceased and in lieu of flowers.

Dr. Joseph R. Jehl, Chairman of the Committee on Medical Defense and Insurance, discussed Medical-Surgical coverage for members of the Society. After various viewpoints were heard, it was recommended that further notice be placed in the *Bulletin* and the members be polled.

Dr. Shulman informed the members that the Woman's Auxiliary of the Medical Society were conducting two different surveys in connection with data relating to members of the Medical Societies. He urged all members of this Society to cooperate by furnishing the information requested in these surveys.

Dr. Shulman then turned the meeting over to Dr. Paul B. Ferrary who introduced the speaker, Irving Graef, M.D., Associate Professor of Clinical Medicine, N. Y. University Post-Graduate Medical School; Attending Physician at Bellevue and Lenox Hill Hospitals; Associate Editor of *Diabetes*; Vice chairman of the Clinical Society of the N. Y. Diabetes Association. Dr. Graef discussed diabetes.

After a question period, refreshments were served by Mrs. Sidney Brooks, Chairman of Hospitality Committee of the Woman's Auxiliary.

DAVID B. LEVINE, M.D.
Reporter

Salem

At the second regular meeting of the *Salem County Medical Society* on October 19, 1956, three new members were elected: Dr. John A. Surmonte of Penns Grove, Dr. Donald Foster of Elmer Community Hospital, and Dr. Frank A. Xhilone of Woodstown. Dr. Surmonte plans to do surgery in Penns Grove, Dr. Foster is in general practice in Elmer, and Dr. Xhilone is associated with Dr. Frank L. Perry in Woodstown. Dr. W. G. Hume was asked to communicate with the new members and offer them the assistance of the society.

Dr. George Nitshe, treasurer, introduced a representative of Hospital Plan of New Jersey who answered questions about the New Jersey Blue Cross Plan. Dr. William Sprout announced that his Diabetes Detection Committee had enlisted the help of 3 physicians and 3 volunteers.

The chair appointed a standing committee on Health and Welfare, to consist of Dr. Madara and Dr. Lee C. Hummel.

Dr. Hume introduced Dr. Ernest M. Brown, Jr., of the University of Pennsylvania, who spoke on "Newer Concepts in the Management of Arthritis."

W. L. SPROUT, M.D.
Reporter

Woman's Auxiliary • • •

Essex

The Executive Board Meeting of the *Woman's Auxiliary to the Essex County Medical Society* was held on October 15, 1956 at the home of the president, Mrs. Harry Di Giacomo. After a delightful luncheon, attended by 55 of the Board members, plans were discussed concerning two new committees in the Auxiliary, namely the Blood Bank with Mrs. Franklin Mascia, chairman, and the Medical Student Loan Committee with Mrs. Severio Monaco as chairman. A pleasant surprise to each Auxiliary member at the opening luncheon was the receipt of a beautifully systematized booklet containing pertinent data regarding important dates, chairmen and so forth. For this work, we are indebted to Mrs. Paul Aszody.

Through the efforts of Mrs. Asher Yaguda, several Auxiliary members participated in the United Appeals Kickoff Luncheon, held October 3 at the Essex House in Newark. Acting as hostesses were Mrs. Harry DiGiacomo, Mrs. Irving Borsher, Mrs. Anthony Caggiano, Mrs. Philip D'Ambola, Mrs. Don A. Epler, Mrs. Jesse Glazier, Mrs. William Miningham, Jr., Mrs. V. Francis Pakonis, Mrs. H. Roy Van Ness, and Mrs. Edwin Seifert.

The Community Health Committee met at the home of Mrs. Lloyd Felmly, Jr., co-chairman, to discuss the outline of their program for the coming year. Mrs. Asher Yaguda, chairman, announced that the Woman's Auxiliary, in cooperation with the American Cancer Society, the Speakers' Bureau of the Medical Society, and the *Newark Evening News* will present a program at the *Newark News* auditorium on November 21. Two timely films will be shown. Discussion will be conducted by a physician from Essex County.

On October 26 at the Essex House, the Woman's Auxiliary participated in the 82nd Annual Meeting of the New Jersey Health and Sanitary Association. As one of the two county auxiliaries which took an active part, hostesses from Essex included: Mrs. Michael Pierse, Mrs. Carlyle W. Schumaker, Mrs. Joseph A. Bocchini, and Mrs. Harry Di Giacomo.

MRS. EDWIN SEIFERT
Chairman, Press and Publicity

Book Reviews • • •

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

A New Approach to Schizophrenia. By Julius Steinfeld, M.D. Pp. 195. New York 1956. The Merlin Press. ($4.95)

Dr. Steinfeld's death in June 1956 deprived American psychiatry of a colorful, thoughtful figure, of a man who was not content to write off the schizophrenic as doomed to deterioration. In this summary of 25 years of psychiatric study, he presents his theory of schizophrenia as due to an early hunger trauma in the infant. The evidence is impressive. Most psychiatrists will reject the thesis as oversimplified, but none will deny that Dr. Steinfeld has given us food for thought. To reproduce the early hunger trauma, he has devised an ingenious technic of having the patient inhale acetone to produce a controllable acidosis. The author combines both psychologic and somatic concepts of psycho-pathology and combines both psychologic and somatic technics of treatment. Half the book is taken up with case reports, half with the exposition of his theory of schizophrenia. In the back is a brief and somewhat narrowly focussed glossary of psychiatric terms. There is no index.

HERBERT BOEHM, M.D.

Obstetrics. By J. P. Greenhill, M.D. Ed. 11. Pp. 1088 Philadelphia, Saunders, 1955. ($14.00)

The need for a comprehensive, up-to-date book on obstetrics is largely fulfilled by this voluminous but readable work. It is adapted to the requirements of the student and yet it is a useful reference source for the trained obstetrician. Some omissions are evident. In occurrence of hyperemesis no mention is made of some of the newer drugs useful in this condition. Nor is intravenous administration of 50 per cent glucose solution recommended, especially in eclampsia. The author advises the intake of an abundance of water upon rising, during the day and before retiring. The consensus is that unlimited quantities of fluid are contraindicated in attempting to produce fluid balance for the control of edema and in combating toxemias.

Treatment for retroversion in early pregnancy is not regarded by the author as advisable unless it has persisted for fourteen weeks. But by this time many babies are lost which could have been saved by early use of the knee-chest position.

The mechanism of labor is excellently described. Under the subject of anesthesia and analgesia no mention is made of Nisintil®, which properly used, acts effectively and generally prevents the need of scopolamine, with its occasional ill side-effects.

Concerning labor, not enough emphasis is placed on the importance of a large episiotomy in order to shorten the second stage to diminish trauma in premature births.

The chapter on oxytocics is well presented except for the strong advice against their use in possible cephalopelvic disproportion. One of the best uses of such an agent, intravenously, is in borderline cases as a real test of labor without having the patient spend many hours in stress and strain. With judicious use and supervision, an oxytocic will give rapid aid in determining the progress of labor.

Placentas heavier than those associated with a normal newborn of the same size are, in the author's opinion, probably due to the presence of syphilis. The fact is that most of the large fatty placentas occur in fetal erythroblastosis. As viewed here, if the Rh factor is positive, the occurrence of erythroblastosis need not be feared and no therapy be instituted. The ABO factors as possible cause of erythroblastosis are ignored.

LEONARD ZWEIBEL, M.D.

Alcoholism as a Medical Problem. Edited by H. D. Kruse, M.D. New York. 1956. Hoeber. Pp. 111. ($3.00)

"Alcoholism is here defined" it says on page 18 "as the use of alcohol as a beverage, irrespective of amount, place, periodicity or practice." And two pages later we are told that "a majority of adults use alcohol. Abstinence is not the norm." Thus it appears that the "medical problem" (alcoholism) is also the "norm."

This work is the record of a conference on alcoholism sponsored by the New York Academy of Medicine and the New York State Mental Health Commission. Only 11 pages are devoted to treatment. The book consists of 8 talks, one on epidemiology, one on "natural history," one on treatment, and the others on various etiologic theories. After each primary presentation is a record of discussion. The eight authorities have different views. No single thesis is espoused. In general, the effort is made to identify alcoholism as a "disease," thus transferring responsibility for control of drinking from the patient to the doctor. In our culture a disease is an affliction which falls on a person and which the physician will treat. This is a naive view of alcoholism. It also leads to the *reductio ad absurdum* of saying that alcoholism, being only a symptom, is not the disease itself, so that at one and the same time alcoholism is, and is not a disease. It is on this theory, a peculiarly self-induced

disease. The standard psychodynamic view is ably presented by Franz Alexander while August Hollinghead offers the sociologic view. Ralph Kaufman faces up to the fact that you can recognize the alcoholic as sick without classifying alcoholism as a disease. He points out that alcoholism is a defensive-adaptive reaction much like fever: and no more a disease than fever is a disease. While this little book may not answer any questions, it certainly raises them.

HENRY A. DAVIDSON, M.D.

Pediatrics. Edited by Donald Paterson, M.D. and John McCreary, M.D. with chapters by 36 other authors. Philadelphia 1956, Lippincott. Pp. 654. ($14.00)

Written primarily for the general practitioner, this book emphasizes common problems like vomiting and diarrhea. Only 50 pages are devoted to the newborn. There is an excellent, concise section on fluid and electrolyte balance. Mental retardation and behavior disorders are, unhappily, grouped together in the same chapter. There is an empty chapter on disturbances of adolescence. Some authors make reckless use of tradenamed drugs, while—with bewildering inconsistency—the drug tabulation in the appendix uses generic names. The material on discipline and emotional problems is amateurish and dogmatic (Example: "Coaxing a child to take food should not be permitted under any circumstances whatever." How wonderful to be that sure, how comforting to be that rigid, allowing of no exceptions ever). There is a 2½ page chapter on public health and school services which is so superficial and skimpy that it might as well have been omitted.

Most of the text is grouped by body system—diseases of the alimentary tract, diseases of the cardiovascular system, diseases of the ear, nose and throat, and so on. When the authors get down to the daily bread of pediatrics, they are compact, practical and useful. An excellent appendix tabulates drug therapy, suggests diet patterns and lists normal values in blood, liver and body fluid tests. There is a highly useful chapter on therapeutic technics.

RALPH N. SHAPIRO, M.D.

J. A. M. A. Queries and Minor Notes. St. Louis, Mosby. 1956. Pp. 334. ($5.50)

One of the most interesting and widely read sections of the J.A.M.A. is "Queries and Minor Notes." The editors of the *Journal* have recognized this and for several years have compiled collections of Queries and Minor Notes. The present volume deals with those published during the year ending June 1956.

The book is divided into 12 chapters, each representing a major body system ranging from the body as a whole through the cardiovascular, respiratory, digestive, urogenital systems and so on. The final chapter covers subjects not easily classified. Each chapter in turn is further subdivided into smaller topographic units. Every subject is dealt with strictly as question and answer material or notes from physicians.

A good serviceable index appears at the beginning of the book with the principal topic of each question listed. An interesting feature is the fact that often answers to unusual or controversial questions are given by two or even three consultants so that a more rounded and diversified answer results. Sometimes no direct answer is given to a specific query or queries, the subject being discussed only in general terms.

Most of the questions are submitted by general practitioners. The answers are the opinions of authorities in their fields. This book makes for interesting reading and is at the same time informative and often of value to the average physician who may have similar vexing problems.

SIDNEY HARRIS, M.D.

Diagnosis and Treatment of Peripheral Vascular Disorders. By David I. Abramson, M.D. Pp. 537. New York, Paul B. Hoeber, Inc., 1956. ($13.50)

Dr. Abramson, Professor of Medicine at the University of Illinois, has prepared a comprehensive and practical guide to the diagnosis and treatment of a troublesome group of diseases. This volume on peripheral vascular disorders is a well written account of the conditions met in ordinary medical practice. Tables, photographs, x-ray reproductions and color plates amplify the text. The book starts with a concise guide to the differential diagnosis of signs and symptoms in peripheral vascular disorders. Included here are details of practical diagnostic tests which can be carried out without elaborate equipment.

Part two, the largest section of the book, is an orderly review of the clinical disorders. It provides a detailed account of drugs, biologicals, diets and physical measures useful in the management of these disorders. Recommendations are included as to when surgery is indicated or to be avoided.

The final section of this book summarizes the anatomy and physiology of the peripheral circulation, pathology of intravascular blood clotting and its prevention, and pharmacologic consideration of drugs used in this field.

This well written and nicely illustrated volume will prove useful to all physicians interested in the diagnosis and treatment of peripheral vascular disorders.

FRED B. ROGERS, M.D.

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† Obituary
e—Editorial
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TUBERCULOSIS *Abstracts*

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A NOTE ON THE ASSOCIATION OF EMPHYSEMA, PEPTIC ULCER AND SMOKING

By Francis C. Lowell, M.D., William Franklin, M.D., Alan L. Michelson, M.D., and Irving W. Schiller, M.D., The New England Journal of Medicine, January 19, 1956.

This discussion suggests a relation between emphysema, peptic ulcer and smoking and tentatively places a heavy responsibility on the last in the pathogenesis of the first two. In the course of the past eighteen months, 25 patients with chronic obstructive pulmonary emphysema were studied. These patients were unselected and came under observation only because of advanced pulmonary disability. A review of the histories in this group revealed that all had been heavy smokers, and with the exception of one male patient who stated that he had smoked cigars exclusively, all had smoked cigarettes for twenty years or more. Some had stopped smoking when respiratory symptoms developed. A history of smoking has been consistently found in patients with cough syncope, a not unusual concomitant of pulmonary emphysema.

The group comprised 19 men and 6 women, ranging in age from fifty-one to eighty-one years. All complained of dyspnea of three or more years' standing, and, except for 3 male patients with cardiac disease apparently secondary to their pulmonary lesion, none had any recognizable cause for their respiratory symptoms other than the presence of obstructive change in the airway. All had some reduction in the vital capacity and marked slowing of expiration as demonstrated by the expirogram, less than 50 per cent of the vital capacity being exhaled in the first second. The residual volume was 50 per cent or more of the total capacity in all 11 patients in whom this measurement was made. Three patients, all males, in this group had bronchogenic carcinoma. Eighteen patients were treated intensively with steroids, and although symptomatic improvement was clearly induced in 16, none had more than slight, or, at best, moderate improvement in lung function as judged by the expirogram or by more elaborate tests of pulmonary function.

Unfortunately, the criteria by which emphysema, as the term is used here, is to be distinguished from bronchial asthma, have never been clearly established. The distinction can be made. Asthma usually begins early in life, but irrespective of the age at onset, periods of severe dyspnea—associated with a reduction in maximal expiratory rate—tend to alternate with periods of normal or close to normal exercise tolerance and pulmonary function can be restored with intensive steroid therapy. In the progressive and often ultimately fatal form of obstructive pulmonary disease referred to here as emphysema, there is usually no dyspnea or other evidence of functional impairment of the lung before the age of forty, there is a gradual loss of pulmonary reserve and once respiratory symptoms have become manifest, there are no complete remissions. Finally, the maximal expiratory rate is markedly reduced, an abnormality that can be at best only partially removed by intensive treatment with bronchodilator drugs or steroids, or both. All patients in the group of 25 mentioned above fulfilled these criteria.

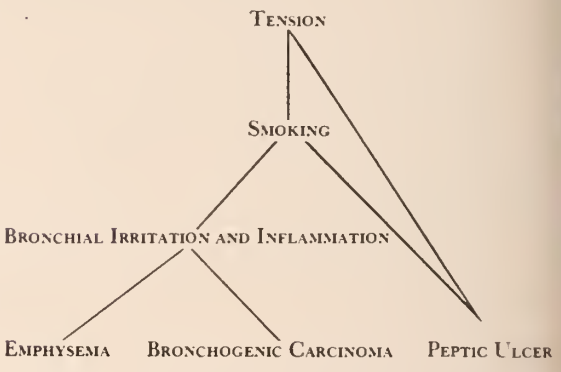
Certain features of emphysema can be explained by the assumption that the disease is an inflammatory lesion of the bronchial tree caused by the inhalation of minute irritating particles. The emphysematous patient with dyspnea and obvious obstruction to expiration often has a remarkably

silent chest on auscultation. In contrast, the asthmatic patient with dyspnea usually wheezes audibly. In asthma, obstruction may be chiefly in the relatively large noise-producing airways. whereas in emphysema this may be restricted to the terminal portion of the airway. Here, the small caliber of the airway and the low velocity of flow minimize turbulence, the cause of wheezes and rhonchi. Such a distribution of the lesion in the two conditions might arise from a difference in the size of the particles inhaled, those recognized as causes of asthma (pollens, mold spores and dusts) being relatively large and tending therefore to settle out in the larger airways, and those that we believe to cause emphysema (smoke and possible fumes and certain industrial dusts presumably acting as irritants) being minute and therefore capable of reaching the periphery of the lung.

We were further struck by the occurrence of peptic ulcer in 6 of the 25 patients with emphysema referred to above, a prevalence of 24 per cent. That this was not mere chance is suggested by other published reports emphasizing such a relation.

An association appears to exist, therefore, between cigarette smoking and emphysema on the one hand and emphysema and peptic ulcer on the other. We believe that the presence of cigarette smoking in this association is best explained as a cause in emphysema and an aggravating circumstance and possibly a cause in ulcer. Such an assumption explains the following: the finding that all of a group of 25 patients with emphysema were cigarette smokers of long standing; the reported description of the lesion in emphysema as inflammation and obstruction of the peripheral and narrow portion of the airway; the widely held opinion that smoking aggravates peptic ulcer; the frequency of peptic ulcer in patients with emphysema; and the occurrence, in the group of 25 patients with emphysema, of 3 cases of bronchogenic carcinoma, a disease for which an association with cigarette smoking appears to have been established.

The quantity and manner of smoking (inhalation) or both may be influenced significantly by the personality of the subject, which is here regarded as having a direct bearing, therefore, on the development of both emphysema and peptic ulcer. A simple schema representing the interrelations herein postulated is as follows: "Tension" is loosely used here to represent a constellation of emotional states and habits ordinarily attributed to those who are anxious, frustrated, ambitious and so forth and who, perhaps because of added factors may be led or pushed to smoke. Relations other than those indicated may also exist—for example, anxiety produced by respiratory difficulty causing or aggravating ulcer.



It is therefore suggested that emphysema and perhaps peptic ulcer as well should be assigned a place along with carcinoma of the lung in the tobacco controversy. Intensive study of this question appears to be warranted since emphysema as defined above is a disease more common than carcinoma of the lung and has a prognosis almost as gloomy.

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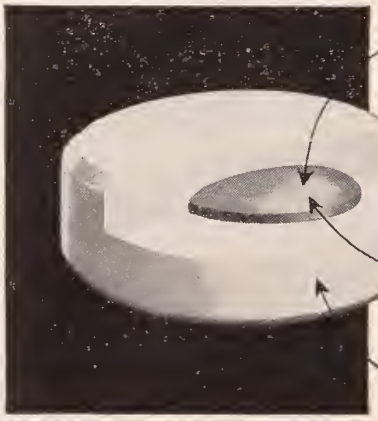
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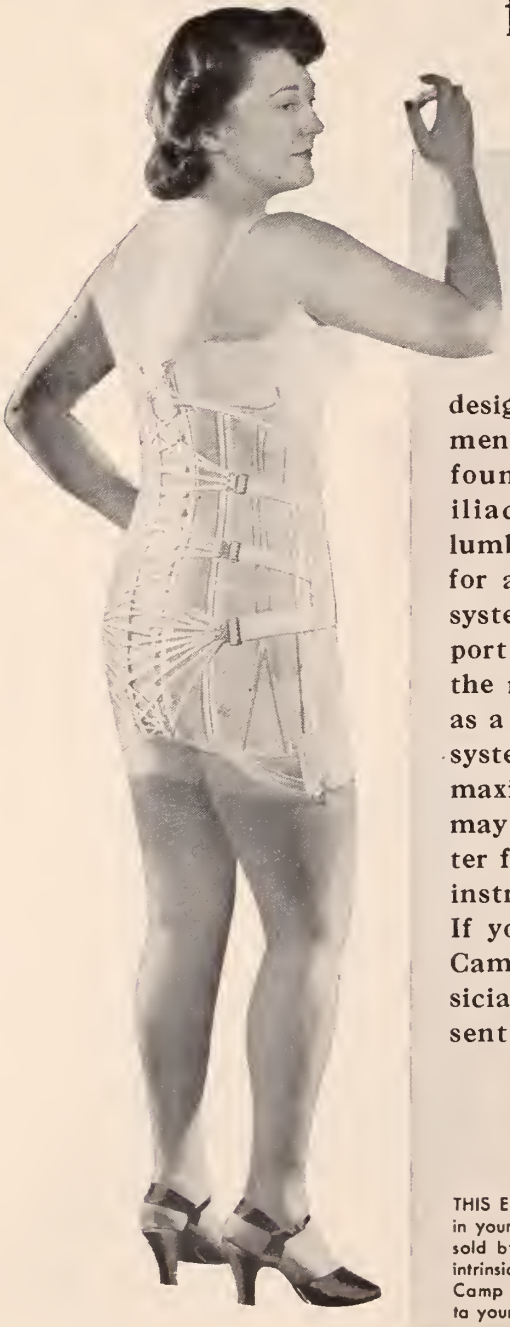
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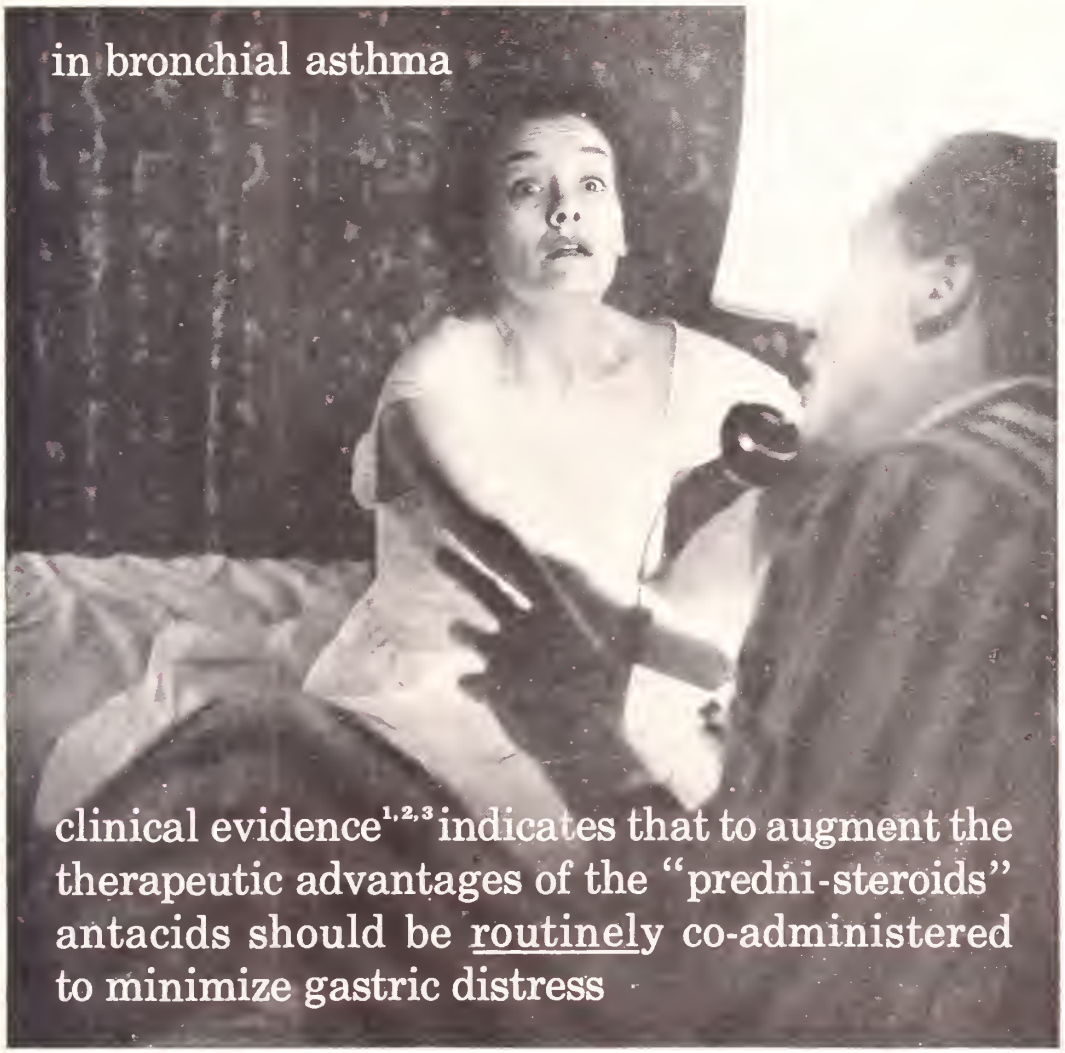
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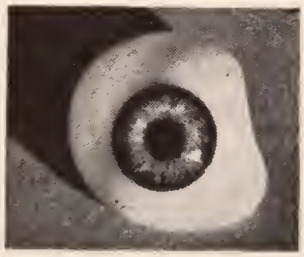
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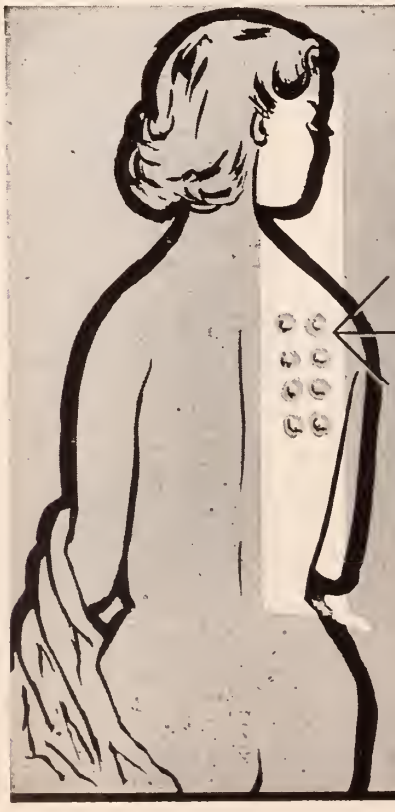
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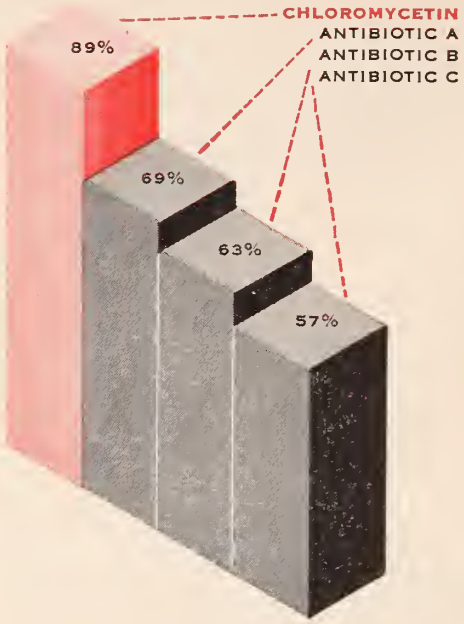
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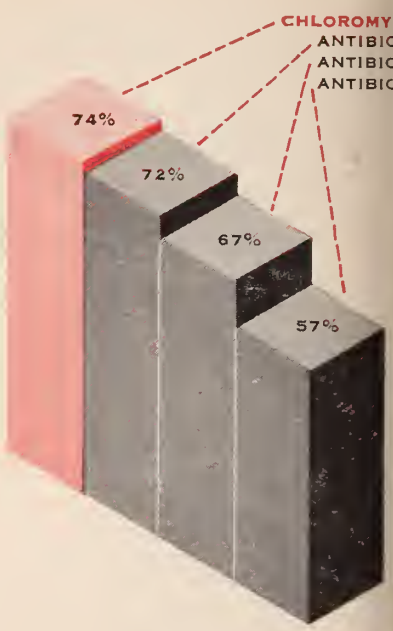
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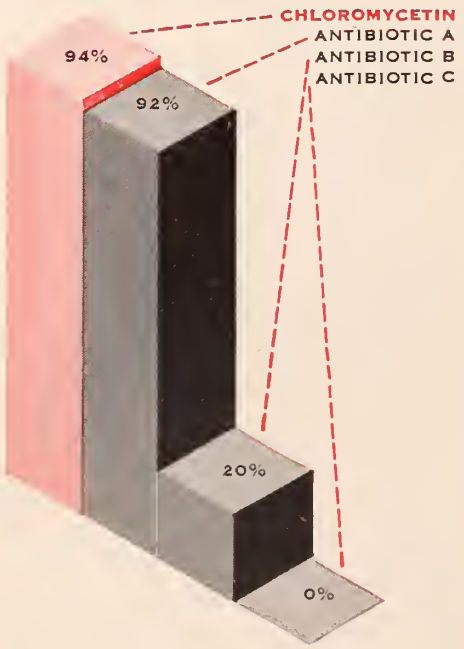
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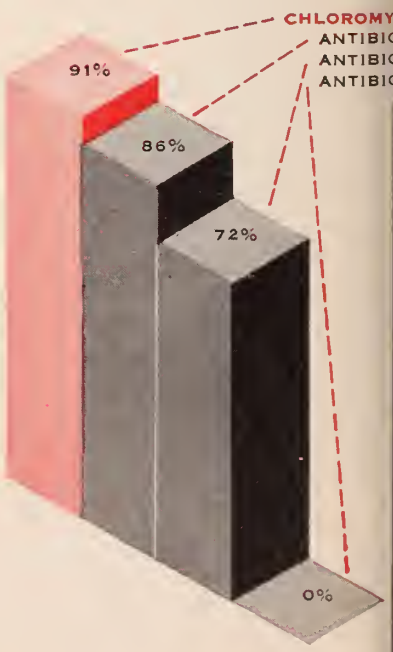
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